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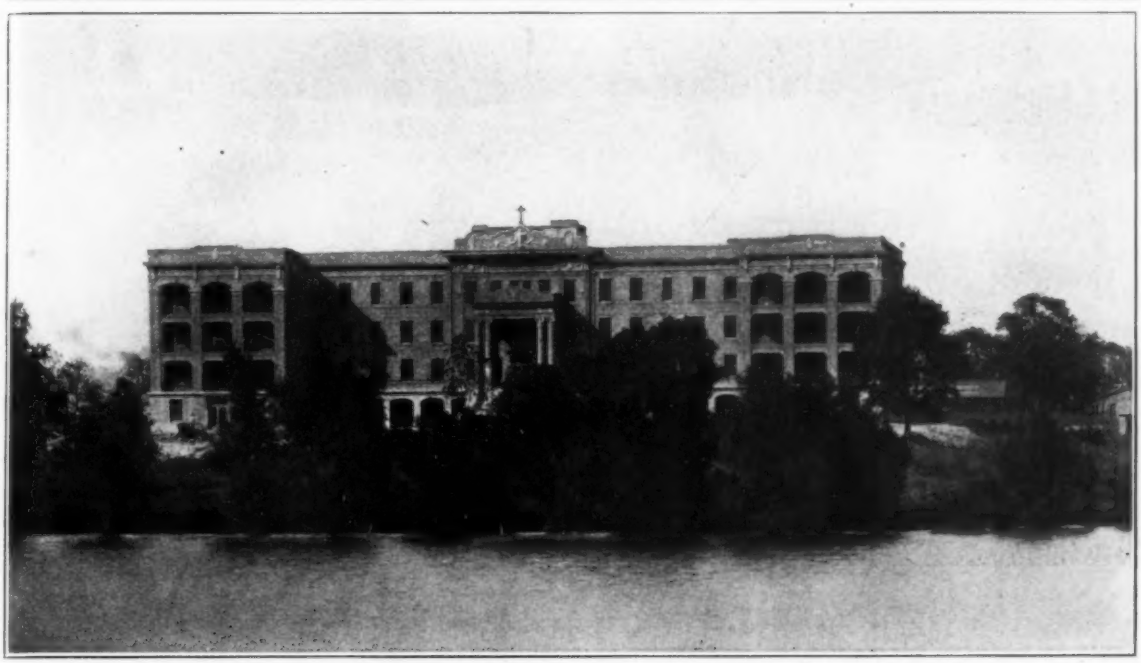


VIEW OF THE SANITARIUM TAKEN FROM THE GROUNDS OF THE LOUISIANA STATE UNIVERSITY ACROSS UNIVERSITY LAKE.

South Has Beautiful New Sanitarium

Our Lady of the Lake Sanitarium, Baton Rouge, La.

ONE of the most recent additions to the new and modernly equipped hospitals of the country is Our Lady of the Lake Sanitarium, on the bank of University Lake at Baton Rouge, Lousiana.

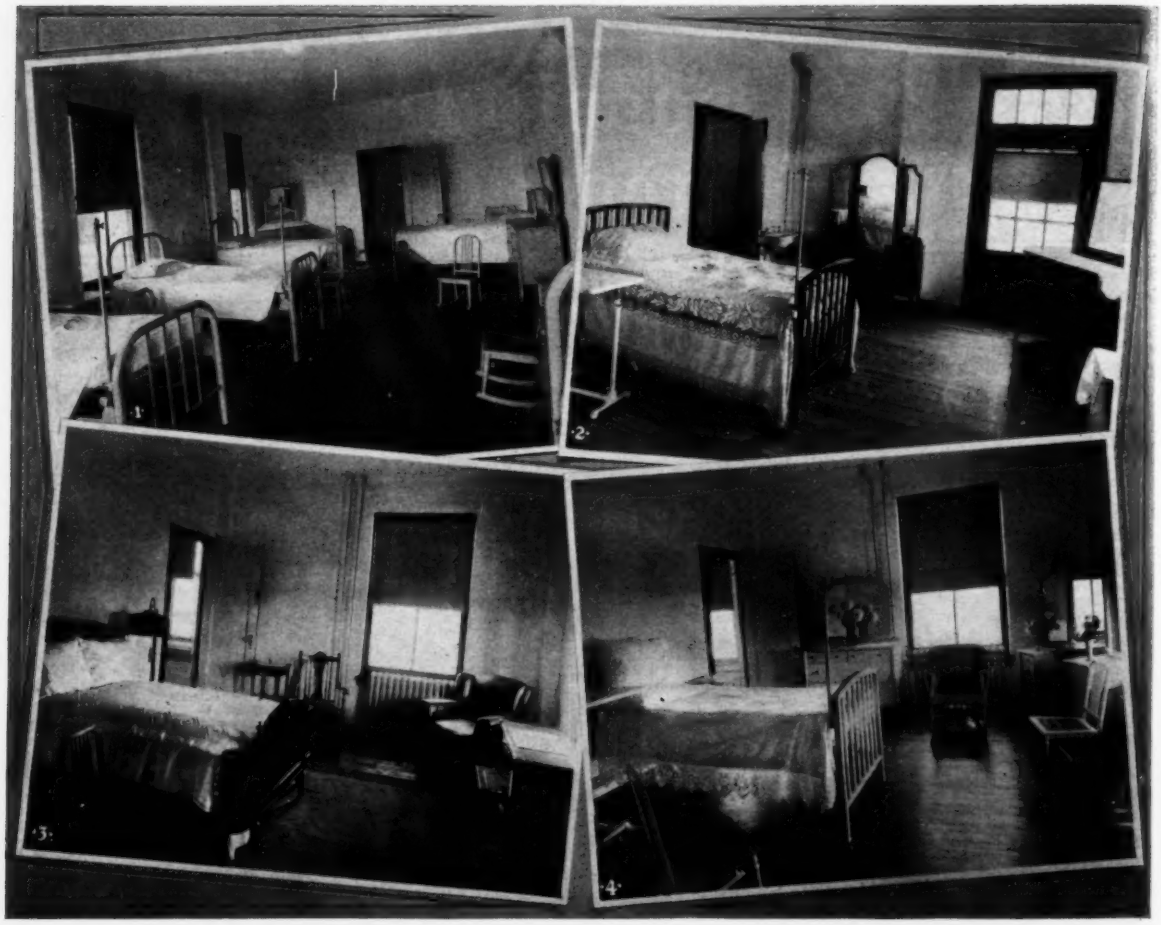
Mother Marie de Bethanie and a nursing corps of Franciscan Sisters from the St. Francis Sanitarium of Monroe, Louisiana, have taken over the management of the new institution, completed in November, and are receiving enthusiastic cooperation from the city and its medical profession. Mother Marie de Bethanie brings to the organization, executive ability and years of hospital experience.

Hill, valley, and lake have made of Baton Rouge a garden spot where tired souls and spirits may mend with returning health. Sacrificing nothing of science and practicability, the imposing structure of cream brick and reinforced concrete stands in harmony with its setting, a thing of service and beauty.

Our Lady of the Lake Sanitarium is a complete, general, modern hospital of 125 beds, conveniently close to the city and at the same time removed from the disturbances of city life.

Entering the sanitarium from the lake side one comes upon the beautifully designed porch, which is a striking bit of the architecture.

In the east wing of the first floor are kitchens, dining rooms, store rooms, and refrigerating plant. Pathological, bacteriological, and x-ray laboratories; emergency operating rooms, and autopsy room occupy the west wing. A completely equipped laundry installed by the American Laundry Machine Company is adequate for the needs of a 300-bed institution. The ice plant, put in by the Wittenmeier Machinery Company of Chicago can turn out 1,500 pounds of ice daily besides caring for the refrigerating plant and the ice water system on every floor. The boiler room has high



1. EVERY WARD HAS A CONNECTING BATH AND OTHER UTILITIES. 2. ALL STEEL FURNITURE IS USED THROUGHOUT. 3. A PRIVATE ROOM WITH ADJOINING BATH. 4. EVERY ROOM AND WARD IS EQUIPPED WITH SIMMONS ALL STEEL FURNITURE IN IVORY OR WALNUT.

and low pressure boilers for all purposes. The kitchens were furnished in detail by the John Van Range Company and are easily accessible from the dining rooms, which accommodate a very large personnel.

Special care was exercised in the planning of the laboratories, or scientific wing of the building. A full-time resident pathologist, M.D., is in charge, assisted by a Sister technician.

The x-ray laboratories are equipped with the latest Victor picture, fluoroscopic, and high voltage deep therapy machines, and are directed by a competent roentgenologist. Radium is available for treatment purposes. A large, well-ventilated autopsy room and the emergency operating room are situated near the laboratories.

On the next floor, off the portico, are the lobby, offices, record-room, waiting rooms, and parlors, and private rooms and wards accommodating about forty patients. On this same floor are the drug rooms with a Sister in charge, and offices for the superior and the superintendent of the training school.

Records

The record room, just off the main office, maintains complete records of all patients. The card-index and cross-indexing system, with the nomenclature of the United States Public Health Service, has been adopted. The forms are approved by the American College of Surgeons.

The department is under the supervision of a graduate nurse, and the work is recognized as an important means to the best possible care of the patient, since the record system is an index to hospital efficiency. No record may be taken from the record room unless by a staff member who has the privilege of access to the records, or upon court order.

The patient's record dates from the time of admission. A case number is assigned him and in the event that the patient returns at another time, he again receives this original number, which is recorded in the entry book under alphabetical index. After the patient has been discharged his complete record is filed, serially, in a folder bearing the case number. The date and the condition of the patient are noted by the physician in charge.

Within twenty-four hours after admission, a general history and a physical examination have been recorded. These are dictated, and typed by a stenographer. These sheets, with other reports such as

routine laboratory, x-ray examinations, nurses' records, temperature charts, doctors' treatment record, progress record, etc., are kept on a steel chart holder in the chart room, where they are plainly seen, the patient's room number over each.

A complete case record at the sanitarium consists of the personal history, physical examination, clinical laboratory reports, x-ray reports, pathological reports, operative and anesthetic report, progress record, autopsy report, nurses' record, temperature chart, and physician's treatment record. When the hospitalization of a case terminates, the record is completed and signed by the doctor in charge. The case record is forwarded to the record room, where the person in charge examines it carefully and notes any incomplete cases, calling them to the attention of the doctor in charge. After final examination of records, they are filed serially according to case number. All diseases, operations, and conditions are cross-indexed by the numbers classified by the United States public health nomenclature.

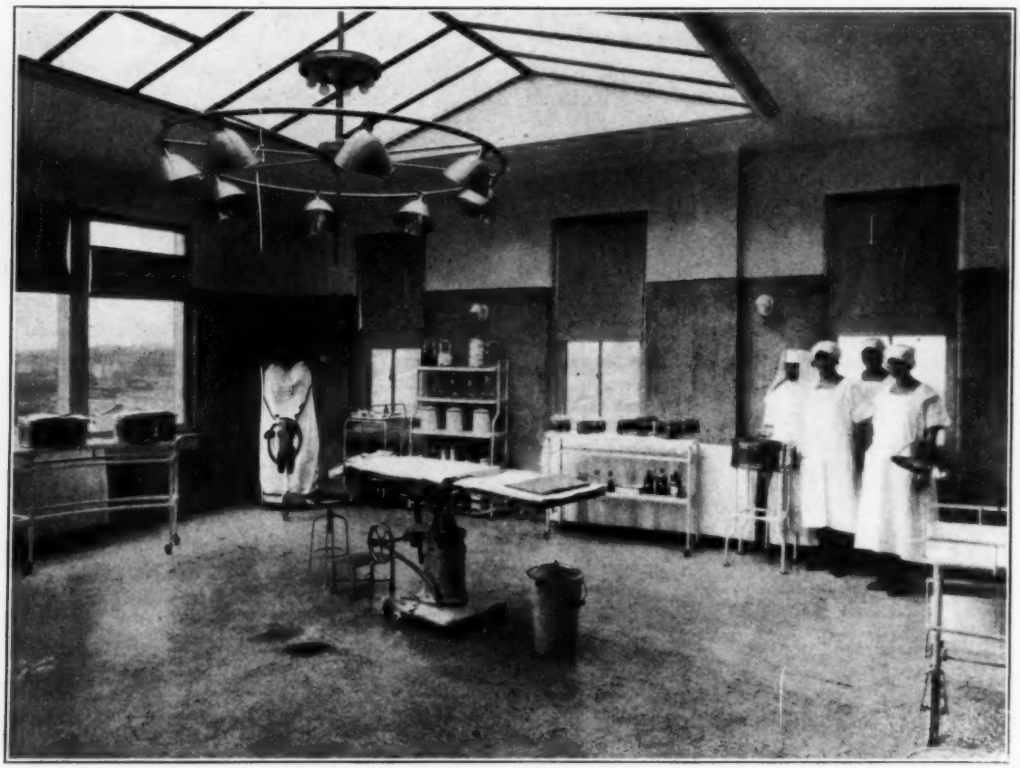
On the next floor are private rooms and wards for about sixty patients. A distinctive feature of the hospital is the service rooms in the center of the building at the back and away from the main corridor. Here in the nurses' chart room is a register connected with the silent call system; the buzzer sounds in the floor diet kitchen, adjacent. Simmons all-steel furniture is used throughout, and every bed has a head-rest, a towel rack at the back, and a portable bar for the suspension of Murphy-drip cans. Practically all rooms and wards have connecting bath, toilet, and pan rooms, resulting in economy of steps for the nurses.

Surgery

In the west wing of the fourth floor is the operating department, consisting of two beautiful operating rooms for general work, one for specialties, and one for emergencies; specialists' rooms, sterilizing, scrub, and supply rooms; obstetrical rooms; rest rooms for the doctors and nurses; and doctors' dressing room with bath. This department is equipped with White Line furniture, and has been pronounced complete by the profession.

The operating suite has gray terrazzo floors, white painted walls, and white enameled tables, glass-topped. The operating rooms have Balfour tables; a table for instruments, stands for sterile water basins, table for suturing material and equipment, stand lights, nitrous-oxide and oxygen machines (McKesson make), anes-

1. FOR SERVICES PATIENTS MAY BE WHEELED TO THE BALCONIES OVERLOOKING THE SANCTUARY OF THE SISTERS' CHAPEL. 2. OFFICE OF THE SUPERINTENDENT OF NURSES. 3. DECEMBER SUNSHINE FLOODING ONE OF THE MAIN CORRIDORS. 4. VIEW OF RECORD ROOM SHOWING CORNER OF MAIN OFFICE TO THE RIGHT. MOTHER SUPERIOR'S PRIVATE OFFICE IS BETWEEN THESE TWO ROOMS. 5. THE ENTRANCE, WITH MAIN OFFICE TO THE RIGHT.



ONE OF THE OPERATING ROOMS.

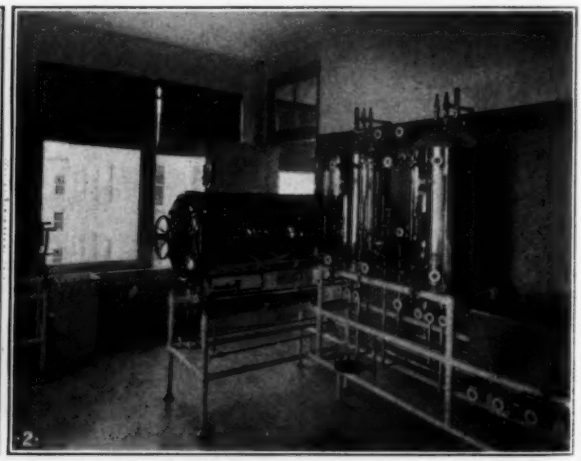
thetist's table and equipment. Northern and western exposure, supplemented by sky-light, provide excellent light.

The sterilizing room is furnished with White Line high pressure steam sterilizer, basin and instrument sterilizer, and sterile hot and cold water tanks.

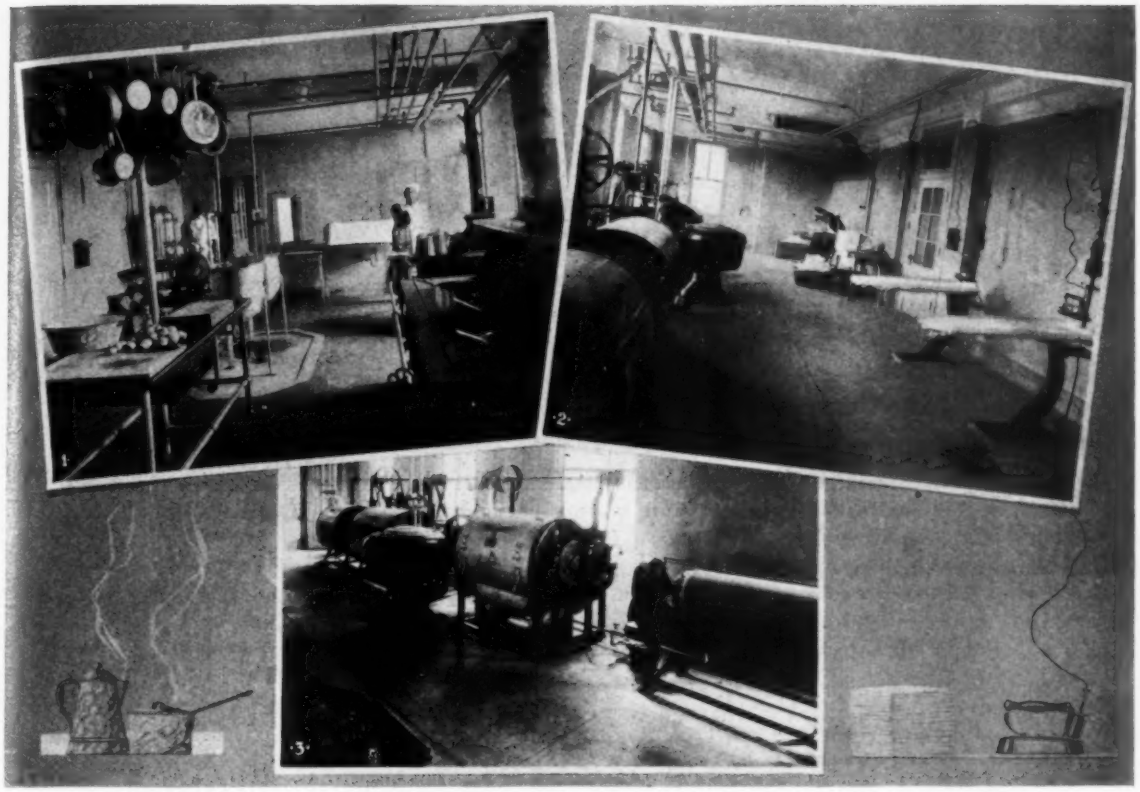
The operating department is under the direct supervision of a Sister registered nurse, assisted by one graduate nurse and six senior student nurses. Routine requires that all members of this service begin promptly at the hour assigned them, and every one makes an effort to maintain a congenial, cooperative personnel.

Before the patient is taken into the operating room, except in absolute emergencies, it is expected that there has been taken a complete record of the case: namely, the general history, the personal, physical examination; urinalysis and blood examination; and the pre-operative diagnosis. Surgical procedure, operative findings, and post-operative diagnosis are dictated on completion of each operation. Pathological cards and specimens are sent to the laboratory for diagnosis. In such cases as suspected malignancy, the pathologist is notified in order that he may be prepared for a frozen section and make an immediate report to the surgeon operating.

OPERATING ROOM WITH McKINNEY FRACTURE TABLE.



THE STERILIZING ROOM.



1. THE MAIN KITCHEN. 2. FRESH LINENS ARE PROVI DED AS MANY TIMES DAILY AS THEY ARE NEEDED. 3. ONE SIDE OF THE STEAM LAUNDRY.

Maternity Department

Also on the fourth floor is the maternity department with an up-to-date nursery and every convenience for at least twenty-five mothers and as many babies.

The sanitarium has given special attention, time, and resources to the establishment of a modern obstetrical service based on recognized developments. The delivery room is equipped with an obstetrical bed, an anesthetist's table and equipment, nitrous-oxide, oxygen machine, instrument tables, stand light, two resuscitating basins and stand, small baby basket and stand to receive the new-born. There are bath-rooms, linen closets, and a much appreciated rest room for the doctors. The maternity rooms are bright, cheerful, and comfortable, and the rules of nursing are rigidly enforced.

A careful system of records in this department provides a case number for the baby, and a record including history, identification band, weight, temperature, chart, and nurse's record of care.

The nursery is a well-ventilated, well-lighted room and has twelve baby cribs, a wardrobe basket attached to each. Bathing tables have scales, electric reflectors, and all supplies necessary for the new-comer.

For the present, the nurses are lodged in the east wing of this floor.

Our Lady of the Lake Sanitarium is the realized dream of the Right Reverend F. L. Gassler, V.F., Dean of Baton Rouge, through whose instrumentality the Sisters of St. Francis were invited to the city, and through whose efforts they were able to accept the offer made them.

Catholics, Protestants, and Jews have worked together in securing this Sisters' hospital for Baton Rouge, and the results promise to be most gratifying. In anticipation of a growing need the management has provided that additions may be built as it becomes necessary to increase the bed capacity.

When the sanitarium has organized its competent medical and surgical men, as it is now preparing to do, it will have complied with the last requirement for recognition as an accredited institution.

Training School

The training school connected with the hospital has a three-years' course including exhaustive lecture studies; class work; dietetics and cooking; obstetrical nursing; general, adult, and child nursing in medical, surgical, and other diseases; massage and physiotherapy. The work is carried on under the direction of the Franciscan Sisters who are registered nurses.

Courses Offered

First Year—First Half Term

Instructor	Subject	No. of Hours.
Supt. of Nurses	Nursing Procedure (2 hr. periods)	64
Dr. McMahon	Anatomy and Physiology	32
Dr. McHugh	Hygiene	6
Dr. Devron	Bacteriology	10
Dr. Jones	Surgery	10
Supt. of Nurses	Drugs and Solutions	8

NURSING STAFF OF ST. FRANCIS SANITARIUM, MONROE, LOUISIANA, FROM WHICH WAS TAKEN THE NUCLEUS OF THE BATON ROUGE NURSING STAFF.

Supt. of Nurses	Hospital Housekeeping	10
Supt. of Nurses	Ethics, (including social and ethical principles)	8
Dr. Bird	Bandaging	10
	TOTAL	158

Second Half Term

Supt. of Nurses	Nursing Procedure (2 hr. periods)	32
Dr. Lorio	Anatomy and Physiology	16
Dr. Paulsen	Materia Medica	8
Dr. Robert	Chemistry	8
Supt. of Nurses	Massage	8
Supt. of Nurses	Nursing Ethics	8
Dietitian, Miss Dunn	Dietetics (2 hr. periods)	32
Dr. Trahan	Medical Diseases	8
	TOTAL	120

Second Year—First Half Term

Dr. McGhee	Medical Diseases	14
Supt. of Nurses	Medical Nursing	10
Dr. Weiss	Eye, Ear, Nose and Throat	6
Supt. of Nurses	Eye, Eear, Nose and Throat Nursing.	4
Dr. Eidson	Materia Medica and Therapeutics	16
Dietitian, Miss Dunn	Dietetics (2 hr. periods)	32
Supt. of Nurses	History of Nursing	8
Supt. of Nurses	Drugs and Solutions	8
Supt. of Nurses	Special Therapeutics (including occupational therapy)	10
Dr. Devron	Laboratory Technique	8
	TOTAL	116

Second Half Term

Dr. Chamberlin	Surgical Diseases	10
Supt. of Nurses	Surgical Nursing	10
Supt. of Nurses	Operating Room Technique	8
Dr. Cushman	Communicable Diseases	10
Supt. of Nurses	Communicable Diseases Nursing	6
Dr. Riche	Obstetrics	10
Supt. of Nurses	Obstetrical Nursing	6
Dr. Riche	Gynecology	8
Supt. of Nurses	Gynecology Nursing	4
Dr. Kemp	Orthopedics	6
Supt. of Nurses	Orthopedic Nursing	4
	TOTAL	80

THE OBSTETRICAL ROOM IS GAY WITH PERPETUAL SUNSHINE.

THE CAFETERIA FOR NURSES.

Third Year—First Half Term

Dr. Tyler	Pediatrics	10
Supt. of Nurses	Pediatric Nursing	6
Supt. of Nurses	Infants' Feedings	6
	Mental and Nervous Diseases	10
Supt. of Nurses	Mental and Nervous Nursing	6
Dr. King	Venereal and Skin Diseases	10
Supt. of Nurses	Venereal and Skin Disease Nursing	4
Dr. McHugh	Public Sanitation	8
	TOTAL	60

Second Half Term

Supt. of Nurses	Social and Professional Subjects	24
Dr. Bird	Emergency and First Aid	10
	Elective Subjects	10
	TOTAL	44

Elective Subjects

Laboratory Technique	10
Institutional Administration	10
Private Nursing and Obstetrics	10
Public Health and Social Service	10
Invalid Occupation	10
Housekeeping Problems of Industrial Families	10
Special Disease Problems (advanced work in any special forms of disease studied in previous lectures and work)	10

GRAND TOTAL.....586

NOTE: The elective subjects may be selected by the student at the end of her theoretical course—according to the future line of work of each student, as selected by her. Each student may select at least one subject.

The Problem of the Neurasthenic

F. J. Hirschboeck, M. D., St. Mary's Hospital, Duluth, Minn.

THE diagnosis of neurasthenia was frequently made 25 years ago. Under this vast heading were often cataloged conditions which, in the light of our present knowledge, we know definitely were not related to neurasthenia except in their subjective symptomatology, there being evidences of disease from the objective standpoint which were characteristic of their clinical entities. The diagnosis of neurasthenia was common for conditions such as hysteria, melancholia, dementia praecox, incipient general paresis, and other organic nervous diseases, tuberculosis, Graves' disease, and ordinary temperamental deviations.

A little later, and within the time of our recollection, it was thought inadvisable to make a diagnosis of neurasthenia. A resort to the name was considered a refuge for ignorance, and it was thought that it should be discarded.

Knowing what we do today, and profiting by the achievements of our diagnostic methods in eliminating organic disease, we again employ the term neurasthenia to designate a condition. This condition is characterized by a complexity of subjective symptoms of general or local distribution, with a tendency to localization at a site of weakened physical resistance or at a locus of mental concentration. The neurotic individual, like the poor, is forever with us. Probably one-sixth of the human race is afflicted with the stigmata of a substandard psycho-neurologic system, which makes them the everlasting problem of the practicing physician and a fruitful financial asset to the quack.

Adler classifies neurotics in three groups, the main group consisting of the ordinary neurasthenic who is not considered abnormal but who may be placed in the lower strata near the minimal threshold of normality in respect to his nerve organization and balance. If the condition recedes below this point we have evidences of degeneracy, exemplified commonly by the dipsomaniac, morphine habitue, and numerous criminals. It is difficult sometimes to separate these cases diagnostically from actual psychopaths, as the line of cleavage between the ordinary neurasthenic and the psychopathic individual is not clean-cut and definite. Other neurotics, the third group, on the contrary, by a substitution of some object which is a safety valve for the expenditure of their energies, and a concentration point for the development of mental faculties frequently latent in the neurotic individual, develop into geniuses who are the pride of our race in almost every field of endeavor—artistic, scientific, political, or martial. Some individuals during their lives show epochs of every grade of this classification from degeneracy up the scale to genius. The names of Edgar Allen Poe, Strindberg, and Napoleon may be cited as examples.

We may consider that in neurasthenic people the conscious control is reduced by its fatigability and exhaustion, to a point where the autonomic nervous system comes into preponderance and the basic vegetative functions of the body are allowed unrestrained freedom, and fear, anger, and passion enter the stage kaleidoscopically. The sense of self-interest or self-preservation dominates the patient's life. The neurasthenic is reduced to a sad view, corresponding to a child's incapacity for judgment and evaluation, and in justice to himself, in his self-interest he does not discount a pain or a weakness which arises. The average physician is a poor refuge—he refuses to listen; with his material turn of mind he wonders why the individual is not able to discard his concern, and hastily shoos him from the office. As a result, the patient learns to exaggerate and reiterate his complaints in search for a sympathetic ear. A condition of this kind may be racial, as exemplified by the Jews, who Abrahamson believes have become neurotic on account of centuries of persecution with no social or legal solution available as a restitution for centuries of oppression and competition. Is there little wonder that the race is almost totally neurotic as a result of this and the inbreeding, characteristic of the race?

The symptoms of a neurasthenic state develop from waste labor and waste expenditure resulting in fatigue, and a recovery rate which is never commensurate with the fatigability, leading to added increments of exhaustion and a vicious circle ending inevitably in a deterioration of consciousness and control. Materialists may question whether the control centers are smaller in these

individuals, of a lessened molecular stability, or reduced by catabolic toxic factors to a weakened state. It is generally believed that the fatigue induced in persons of this type is due not to catabolic causes or metabolic waste products, but to a primary atonic fatigability of the human economy with a lack of dynamic reserve. Briefly, there is an inadequacy of vital income to vital expenditure; the conscious mental capacity becomes reduced and runs apace with the reduction in the resistance, so that the patient, in his depreciating mental state, turns, as Albutt says, from Shakespeare to novels, novels to newspapers, newspapers to cards, and eventually to exhaustion. Where governmental control weakens, anarchy breeds. Inhibition weakens, and organic and psychic fussiness results, with short-circuiting of the disposition first manifesting itself with outbreaks of temper, crying, moodiness, anger, and profound introspection. The autonomic nervous system retains its vigor for a long time, and these basic vegetative symptoms are painfully persistent. The lack of control may be appreciated when we consider as an analogous situation the tireless irritation of the vesical reflex by the enlarged prostate and the lack of control of this irritability by the higher psychic centers.

The tendency to neurasthenia is hereditary in about four-fifths of the cases but the history rarely shows an atavistic tendency, there being usually a history in the immediate progenitor. Neurasthenic manifestations, although frequent in the child and young adult, do not become marked so far as their influence on their environment is concerned, until stresses and strains incidental to competition in the business world and the exigencies of marital life, bring out their labile incapacity from its latency, and the well developed neurotic symptoms subsequent to their extreme fatigability develop. The general symptoms are marked, but the local evidences give color to the case, and the predominating symptoms may be cerebral, spinal, cardiovascular, gastro-intestinal, or uro-genital.

The neurotic in his adolescence must be nurtured carefully but not pampered, and a choice of occupation must be given due consideration. Toxic factors and acute disease tend to initiate symptoms, and oftentimes mark the beginning of a breaking point. The influence of trauma on so-called "traumatic neurasthenia" is well known, and one might even consider all stresses and strains to which the patient is subjected as psychic or somatic trauma. Post-traumatic cases who have a neurotic tendency, easily develop a traumatic neurosis. Patients who are not neurasthenic and who have symptoms persisting longer than is considered reasonable after injury, may be suspected, on the contrary, of being malingerers.

A somewhat heightened nervous irritability or excitability is not an indication of neurasthenia; it is merely analogous to the difference between a race horse and a dray animal. The more excitable our nerves, the quicker and higher our life; but the method, rate, and degree of recovery vary much in individuals and influence the breakdown.

The *intelligentia* is not necessarily a nervous class. Neurasthenia is fully as common in the ghetto and the bowery, but as most writings on neurasthenia are by men who are specializing in sanitarium treatment, it gives color to the belief that the higher social class of patients is predisposed to it. It is easy for the observer to admire and sympathize with the clever neurotics who regale their symptoms, and to forget the humbler patients.

A diagnosis of neurasthenia should not be made except as a last resort, and a careful differentiation must be made from hysteria, tuberculosis, Graves' disease, atherosclerosis, general paresis, syphilis, anemia, melancholia, dementia praecox, undisciplined individuals, and the so-called "temperament mensch."

The symptoms of neurasthenia are multiple. The patient with a predominance of cerebral symptoms complains of a weary brain; noises annoy him. He is jumpy and swears easily. Headache is a common complaint, usually occipital in type, and diagnostically may be presumed to be neurotic in origin if a simple head rest relieves the aching. The scalp is tender. The afflicted are irritable, their memory is poor, but they are rarely suicidal, as the *tedium vitae* stops short of despair. The so-called "compulsion and anxiety neuroses" are characteristic, but agaro and claustro phobias are hysterical symptoms rather than neurotic, unless there is a superimposition. Insomnia is a common complaint.

In the spinal and muscular type the patients complain of weak backs, pains in the legs, and with this, general muscular and tendinous relaxation and fatigability. Low backaches suggesting strain are common. Paresthesias, numb and dead feelings in the extremities, are frequently observed, but true anesthesia, as in hysteria, does not occur.

The cardiovascular patients with the labile superficial circulation and irritable heart are a common type. They complain of tachycardia, palpitation, subjective sensations of irregular action, fainting, unstable pulse, and poor peripheral circulation; they show the sympatheticotonic habitus with the small drop heart and the long waist, etc.

The visceral type is also well known, and while it was formerly thought that Glenard's syndrome was a forerunner of neurasthenia, we know now that it is a syndrome frequently found in the neurasthenic with visceral symptoms. The habitual gas belcher and the aerophagic, with constant dyspepsia and the irritable colon, are of a class, and an examination shows atony and ptosis of the abdominal viscera, with a tendency to the development of organic reflexes as described by Pawlow, with loose bowels, vomiting, cardiospasm and anorexia nervosa.

The uro-genital and sexual neurasthenic is frequently the most difficult to handle, and the type to whom the Freudian principles apply, much as we depre-

cate the teaching otherwise, to the point of disgust. Traumatic cases are almost a group by themselves, and with them one might place the post-operative neurasthenics, which according to surgeons develop particularly in patients who have had pelvic operations. The traumatic cases are interesting in that they exemplify typically the so-called "defensive reaction," whereby the patient's self-interest or family interest develops a physical and mental incapacity to the point of complete disability.

There is a common belief that hysteria and neurasthenia are more or less similar, but the difference is clean-cut and definite. Hysteria may or may not develop in patients who are not neurotic, but the ordinary neurasthenic is not hysterical. The hysterical patient is usually a woman. The onset is sudden rather than slow, and its course is capricious, not tedious, with intervals of euphoria. Hysterical seizures or fits are absent in neurasthenia, as are also the areas of anesthesia, the joint contractures, hallucinations, and helmet headache. The hysterical patient defies the physician to restore him to health. The neurasthenic grovels at your feet in supplication to make him like his fellow men.

The Public Library and the Hospital

Mrs. Elizabeth Berry, Hospital Librarian, Milwaukee Public Library, Milwaukee, Wis.

THE therapeutic value of good reading is second only to that of music.

When the convalescent is allowed to stagnate mentally, to become lethargic, and to ramble at length and leisure through the highways and byways of his unattractive symptoms, he is almost certain to arrive at the inn of disaster.

This period of convalescence is the psychological time for the right book to quicken his interest, dispel the "blues," lift him out of himself and his surroundings, and stimulate him to a favorable reaction.

THE STANDARD BOOK CART IS A CONVENIENT MEANS OF CIRCULATION.

Making a Choice

The selection of books for hospital reading must be made with the greatest care and always from the viewpoint of the patient. They must be adaptable to bedside handling, light in weight, and printed large on an unglazed surface, the story itself entertaining and vivid, with no suggestion of depressing situations or taint of morbidness.

Men like the striking story of action and enthralling interest. They like Zane Grey, Mulford, Seltzer, Raine, and Bower. They like to follow Curwood and Edison Marshall through adventures of the North. They enjoy Jack London, Joseph Conrad, and Rex Beach, and turn the pages of Peter B. Kyne and Phillip Oppenheim with a peculiar fascination.

Women, on the other hand, are partial to Grace Lutz, Jean Webster, Temple Bailey, Grace Richmond, and the delightfully entertaining Cape Cod narratives of Joseph Lincoln.

No one perhaps can quite measure the joy of the foreigner, sick in a strange land, who finds in the stock of hospital book service, a volume in the language of his learning. The flood gates of his mental life are opened to the endless pleasures of the printed page, and it is as if a friend from his own land had come to spend an entertaining time with him. The eagerness with which the book is accepted, the smile, and the absorbing interest, more than compensate for any difficulty that had to be surmounted to carry that book to the bedside of the man it was written for.

Even those who do not read, or cannot, enjoy having the hospital librarian stop for a little chat. The momentary diversion carries them for the time being away from their ills and introspection.

First Impressions

When library service was first introduced into the sick room patients were suspicious, sometimes a little resentful, and generally loath to avail themselves of the books brought to their bedside. They anticipated a snag in what appeared too good to be true, certainly too good to be free.

But the barrier fell before kind reassurance and intelligent explanation. Reluctance gave way to confidence, and confidence has inspired an enthusiastic interest.

More than once on approaching a ward, I have overheard some of my patron patients explaining to a newcomer that the book lady will bring them books of the kind that most interest them, and it will cost them nothing.

Needless to say, I have made every effort to promote this faith on the part of patients; above all to encourage their free expression of individual preference in reading.

And what varied types of readers there are! How fascinating to study their tastes! One woman of middle age who looked over the books in a disinterested way remarked casually, "I have never read a book but it looks as if I would be here a long time, so I will try one." She selected one of Zane Grey's western stories, and was eagerly waiting for me on my return visit. The book had proved so interesting, she had finished it the following day. Zane Grey's book was only the beginning. This patient, detained for many weeks because she was in a cast, read almost unceasingly during the remainder of her stay in the hospital, choosing always a western story, because stories of sentiment were "too silly for a woman of my age."

A pathetic little old man who had lived in a box car for years while in the employ of a railroad, timidly took a book when the librarian visited him in the hospital. "This don't cost nothing, does it?" he asked, and convinced that it was all free for the taking, he read with a vim. Unlike the woman who had declined love stories, this old man read them all with delight. His spectacles, pressed into unaccustomed service, threatened to fall apart, until a few strips of adhesive tape held the frames intact and dispelled his fears of calamity. It seemed to us that the little old man left almost sorrowfully, the hospital and the beloved books, to return to his colorless life in the box car.

"I would like an easy animal story," says a little Italian boy of 10 or 11 years, whose leg has been amputated; while not far off a little old German lady reads and re-reads a novel in German print. And we are reassured that it is all very much worth while.

As Time Goes On

It has been most satisfying to see the ever-increasing interest of patients, hospital personnel, and doctors, in hospital library service. The time has come when it is not uncommon for both nurses and doctors to request that a book be given to this patient, or that. Good reading has become a recognized adjunct of convalescence.

When the Milwaukee Public Library became a pioneer in this field of work and acquainted hospitals of the city with the service it intended to carry on, the larger institutions purchased, as an essential of hospital equipment, book carts that would facilitate the efforts of the librarian, and smaller hospitals provided tray carts until such time as they might have the standard size.

As the work grew and the need for more books became acute, the library conducted a drive in the Fall of 1922, which met with gratifying response. In the Fall of 1923, the drive was repeated for the double purpose of enlarging the special hospital collection and replacing to a certain extent those books which had succumbed to an extreme popularity. As a result, not only books were given but magazines frequently called for and never available were generously provided through subscription. In the interval between the first and second drives many had had occasion to enjoy and profit by the bedside library, and out of their experience they contributed freely.

A CHILD AND A BOOK—AND A LITTLE MIND GOES TRAVELING THROUGH COUNTRIES NEVER TO BE FORGOTTEN.

At the recent convention of the American Hospital Association in Milwaukee, the hospital library exhibit and display of photographs, charts, and books for hospital circulation, arranged on a standard hospital library book cart, together with Miss Kathleen Jones' new and helpful publication, "Hospital Libraries," created much interest. Throughout the entire convention there was a continuous demand for information on hospital library problems and methods, from those who already had the service, and those who contemplated its installation.

More and more, out of this growing concern for the mental life of the patient, comes the strengthened conviction that the hospital library is no longer a luxury but an essential of hospital regime.

STAFF REVIEWS SYPHILOTHERAPY

At a meeting on February 13th, St. Joseph's Hospital staff of San Francisco, California, concluded its discussions on "Modern Treatment of Syphilis." Specialists were heard on respective phases of the subject.

Dr. Ludwig A. Emge presented obstetrical and gynecological aspects, stressing the prevention of lesions with neosalvarsan and inunctions. The result of this procedure, according to Doctor Emge, will be that three-fourths of the children born of syphilitic mothers will be healthy.

Dr. M. L. Cohn advised inunctions and mercurial injections in hereditary lues for those under one year, and the addition of arsenic for those older than one year.

Dr. J. M. Wolfsohn advocated inunctions of oleate of mercury or blue ointment and neoarsphenamin, as well as spinal drainage and intraspinal injection of mercurialized serum in locomotor ataxia. Bismuth preparations, hectine "A," "B," "C," hectargyre; re-educational movements were evaluated.

The subjects of the program for March 12th were "Medical Improvements Noted in the Old World," by Dr. Alexander Keenan, surgeon to Mary's Help Hospital, and "X-ray as an Aid in Early Diagnosis," by Dr. F. H. Rodenbaugh, radiologist of the same hospital.

St. Joseph's Hospital staff officers for 1924 are Dr. A. S. Musante, president; Dr. Frank Lowe, vice-president; Dr. Louis Overstreet, secretary; Dr. F. C. Keck, treasurer.

Nurse Becomes Supervisor. Miss Mary McMahon, R.N., a graduate of St. John's Hospital, St. Louis, Mo., has accepted the position of surgical and obstetrical supervisor of St. Elizabeth's Mercy Hospital, Hutchinson, Kans.

Spring Lectures. A series of spring lectures for the undergraduate nurses of St. Joseph's Hospital, Omaha, Nebraska, will be given by the Rev. Francis Reilly, S.J., on the subject, "Ideals of True Womanhood."

Lectures of this nature are given each year as a part of the nurses' curriculum.

Practical Psychology and Psychotherapy for Nurses

James J. Walsh, M.D., Ph.D., Sc.D.

This article is the second of a series in which Dr. Walsh gives nurses and hospital workers a background for the solution of present day problems of psychology and psychotherapy. The third article will appear in an early issue.—Editor.

ONE of the earliest documents we have with regard to the advantage that may be derived from the employment of attendants who have had previous experience in the care of the sick, comes from a great French surgeon who lived toward the end of the middle ages but whose textbook of surgery has fortunately been preserved for us. There are so many variants for the spelling of his name, Mondeville, anything that looks even a little like the form we have given may refer to him.

Mondeville had evidently come to realize very clearly how valuable properly trained assistants might be in the successful care of his patients. He did not think he had done his full duty when he had operated; nor did he feel that he might leave the rest to nature and to the patients' own resistive vitality and constitutional tendency to get well. To secure their recovery he realized that he must put them in the best possible condition of mind as well as of body, that nature might be stimulated in every way to make the greatest effort toward their rapid and complete cure. No detail of the patient's environment seemed to him too trivial for attention. He was persuaded that every phase of life—eating, sleeping, resting, and particularly as happy a state of mind as possible—was as important as the surgeon's ministrations for mechanical correction in the body.

He appreciated, above all, the influence of the mind on the body, and how much a cheerful attitude helped the system to use all its forces most advantageously for purposes of convalescence. Mondeville has laid down definite and emphatic regulations for the young surgeon to follow in securing this beneficial mental influence.

"Let the surgeon," he says, "take care to regulate the whole regime of the patient's life for joy and happiness by promising that he will soon be well, by allowing his relatives and special friends to cheer him, and by having some one tell him jokes; let him be solaced also by music on the viol or psaltery. The surgeon must forbid anger, hatred, and sadness in the patient, and remind him that the body grows fat from joy and thin from sadness. He must insist on the patient's obeying him faithfully in all things." He repeats with approval the expression of Avicenna, that "often the confidence of the patient in his physician does more for the cure of his disease than the physician with all his remedies."*

To enable him to secure this state of peaceful confidence and hopefulness on the part of his patients, Mondeville was quite convinced that nursing was extremely important. It is no wonder, with such a conviction, he felt that without good nurses surgery often failed of its purpose entirely. He instructed them how to secure this from the results of his own experience. He had come to the conclusion that for many reasons members of the family, and especially near relatives, were not so likely to fulfil his purposes and obey his instructions in detail as those not of the household, particularly if they had some experience in caring for the sick. Above all, he found that relatives talked too much to the patient, showed their solicitude more than was good, and so disturbed those whom they were caring for. They wanted to do the very best they could and they had the best intentions. This often made them overanxious and their anxiety was communicated to the patient, which was not good for him. Mondeville says specifically that wives do not make good nurses for their husbands, and he had something of the same feeling with regard to mothers and their children, and even other near relatives. Manifestly his idea was that he should have for his cases those who had been particularly instructed, those who could be depended on to do what they were told, and by their equanimity produce such a state of confidence in the patient that he put himself in the best state of mind for recovery.

Mondeville's own words with regard to near relatives seem worth while quoting, lest it should be thought that an enthusiastic lover of the Middle Ages was tempted to put meanings in Mondeville's work beyond what his own words justify. He said:

"Especially are they (near relatives) prone to let drop some hint of bad news which the surgeon may have revealed to them in secret, or even to give some inkling of the rumors that they may have heard from others, friends or enemies. Insinuations of this kind provoke the patient to anger or anxiety and this is likely to give him fever."

In order that nurses might secure the best results for the surgeon and his patients, Mondeville emphasized the fact that they must be obedient, loyal and faithful. He believed that without these qualities they were likely to do more harm than good. Once more his own words are the best indication of his experience:

"For if the assistants (the word he used for nurses, and they were evidently of both sexes) are not solicitous and faithful and obedient in each and every thing which

*Walsh, "Old Time Makers of Medicine," Fordham University Press, 1911. A special edition of Mondeville's writings on surgery was edited by Pagel and published in 1893 (Berlin).

may help in the cure of the disease, they put obstacles and difficulties in the way of the surgeon."

Mondeville evidently depended on the nurses whom he dignified with the name of his "assistants," to be sedulous about the patients' nutrition as well as about the bandages, and to see that the instructions of the surgeon were carried out to the letter. He says that "the surgeon must, therefore, be careful in the selection of his nurses, for some of them obey very well when he is present but do as they like and often just exactly the opposite of what he has directed, when he is away from the case." Earlier surgeons had been inclined to think that patients should not be fed well when they were under surgical care, and sometimes were even prone to say that their diet should be very limited. But Mondeville believed in a good liberal diet unless it was contra-indicated for some special reason. Indeed, he liked to put his patients under the care of his assistants (the nurses) some time before the operation, in order that they might be built up into good condition in readiness for the operation; apparently also that they might be put in a favorable state of mind toward the surgeon and his operative work and also be accustomed to the place where they would spend some time after the operation.

Ordinarily, it is assumed that there could not have been in the Middle Ages any surgical nursing worth talking about because good surgery demands three things: first, good surgeons; secondly, good hospitals; and thirdly, good nursing. This is the tripod on which all successful surgery must rest. If any one of the three legs is missing it will be quite impossible to expect surgery to occupy any safe position. It is usually felt that only in our time have these three conditions developed. With regard to the good surgeons, we shall see that in the older time not a few men did excellent surgical work. As regards good nursing, if Mondeville's words are to be taken as an index of the way surgeons felt about it at that time, there must have been some rather good nursing developed. If the surgeon knows what he wants in the nursing line as well as Mondeville did, provides instruction himself, insists on the careful selection of nurses, and knows what good results he obtains from them, then there can be no doubt that good nurses will develop in connection with his work, for he has laid down all the conditions that are necessary in order to secure them. His words would imply that he had experience with some excellent nurses, and that while there were others who failed him, these exceptions only proved the rule that there must have been many good nurses.

Mondeville knew how much harm could be done by unsuitable or ill-disposed nurses who lacked tact or perhaps the training in unselfish devotion necessary to secure the best results for their patients. He had evidently had some experiences which brought home to him the rather serious disadvantages which might result from this sort of thing. It is not surprising, then, that he thought it particularly unfortunate "if the nurses disagreed or were heard murmuring about what they were asked to do." He felt that patients could scarcely fail to be disturbed by such bickering among their nurses and that only too often they misconstrued what they heard. Patients, he held, would be inclined to think that their nurses' disagreement over the treatment or their duties must have something to do with serious distrust on their part of what they were ordered to give or arrange for their patients. This dissatisfaction on the part of their nurses, patients would inevitably conclude to come from the fact that they were not being treated properly and that, therefore, the outlook for themselves must be uncertain. No wonder that Mondeville more than six centuries ago insisted that his nurses should not wear long faces but should be so cheerful and joyous as to encourage the patients to be of the same mood. This is as much a part of their duty as their giving of proper food and medicine. Mondeville knew how easy it was to disturb a patient's equanimity, and how difficult to win it back, though maintenance of a favorable state of mind was not difficult if the attendants only used the proper means.

One might probably think that surgery was of so little significance six hundred years ago, in the fourteenth century, when Mondeville lived and did his work, that after all what he thought about the place of assistants means very little. His experience presumably was so limited, because the amount of surgery done was so small, that his opinion with regard to the care of patients can signify but little since it had been obtained from the study of so few cases. We are all of us prone to think in terms of what we know of comparatively recent medical and surgical history. Even two generations ago a hundred serious operations a year represented a large number in a hospital, and a surgeon who himself did more than that in any year was a very great rarity. Most of these operations were amputations. Other operations of serious character were undertaken only under stress of necessity. It was a case of operation or death, and very often surgical attention to such patients was delayed until there was comparatively little chance for recovery. It is easy to understand, then, that the opinions of surgeons of that time would mean very little as regards the care of their patients. The surgeons saw only desperate cases, and infections were so common that the one hope of recovery lay in the patient's lucky chances with regard to the mildness of the infection that happened to come his way, since he could scarcely hope to avoid infection entirely.

In Mondeville's time, however, things were very different. He came as a sort of culmination of that great school of surgeons of the later Middle Ages which had arisen down in Salerno early in the thirteenth century. Gradually it had spread to the north of Italy and produced such wonderful surgeons as Hugo of Lucca and his son Theodoric, Bruno of Longoburgo,

William of Salicet, and Lanfranc, the other form of whose name, Lanfranchi, shows that he was an Italian, but who was banished from Italy and then taught at Paris. There, to use the words of Pagel, that great German student of the history of medicine, he "gave that primacy to French surgery which it maintained down all the centuries to the nineteenth." Mondeville, himself Lanfranc's pupil, was followed by Guy de Chauliac, who is often spoken of as the "father of modern surgery." The latter recognized his obligations to Mondeville and quoted much from his writings. De Chauliac evidently appreciated very thoroughly the fact that this man had been a great teacher in surgery because he depended on experiences rather than on theories, had studied all the problems relating to his patients and evaluated them properly, and had not taken any one-sided view nor limited his usefulness to whatever he could do mechanically for his patients.

The more one learns about the histories of these men in surgery, the easier it is to realize that they had extremely valuable experience and that they compare very well in this regard with even the best surgeons of modern time. These Italian and French surgeons operated on the brain for tumor and for abscess, and on the skull for fractures of various kinds, relieving the brain of pressure and doing trephining whenever it was necessary. They operated on the thorax for abscess and for fluid, manifestly having considerable experience with regard to this phase of their work. The surprising thing for us today, however, is that they operated on the abdomen for a number of surgical conditions. Above all, they taught that whenever there was a wound of the stomach or intestines it would have to be repaired or death would surely ensue. They invented various needle holders for the repair of such wounds; they described tubes of various kinds, usually made of silver with flanges (reminding one somewhat of the modern practice of the Murphy Button) which were to be introduced into wounds of the intestines to maintain the patulousness of the intestinal canal during the healing process.

It would seem to us quite impossible that so much operating as this could be done in the Middle Ages. Without anaesthetics patients could not stand the awful pain of the cutting of tissues, and after the operation, would surely die of some form of infection owing to lack of antiseptics. The development of the history of medicine in recent years, however, has brought home to us very clearly the fact that these old surgeons had discovered a method of anaesthesia. There was a vague tradition with regard to this which has now been confirmed by the publication of many sources of medical and surgical history. The English poet, Thomas Middleton, just at the beginning of the seventeenth century, told of "the pities of old surgeons who put their patients to sleep before cutting them." Modern readers were inclined to think this a bit of poetic license which the Elizabethan poet had allowed himself to drift into because he saw what a blessing such a thing would be. It was the poet, however, who talked from facts, while the modern reader misjudged him and attributed to his imagination what really came from his better knowledge of old-time conditions.

The old surgeons used the *spongia somnifera,* the sleep-bringing sponge, and obtained a condition of anaesthesia by inhalations from it. The sponge was soaked in tinctures and other solutions of such substances as mandragora (Shakespeare had Friar Lawrence provide Juliet with a potion of mandrake which would put her to sleep—but a sleep that simulated death—for some forty hours), hyoscyamus, opium, and wild lettuce. The sponge was then dried in the sun and when it was to be used for the production of anaesthesia, according to a very old tradition, was placed in boiling water and the fumes of it inhaled. This anaesthetic was not so safe as our anaesthetics have become through large experience; it was not so dependable in its effect but it did very well in enabling surgeons to perform surgical operations that would otherwise have been impossible. Knowing this, we can understand better the descriptions of even extensive operations which we read about in the old book.

The mediaeval surgeons also developed antisepsis. One of the great Italians said that when a surgeon made a wound which did not heal promptly the surgeon was responsible for the failure. They boasted of getting union by first intention. Indeed that expression, which comes from the Latin words *unio per primam intentionem,* has no meaning unless one knows mediaeval Latin or has been given a special explanation with regard to it. They had discovered the antiseptic qualities of alcohol, though they did not know of antisepsis in our sense. They only suspected the presence of microbes, and very probably thought much more of the possibility of animal tissues decomposing. They dressed their wounds with linen bandages dipped in strong wine, and as the wine evaporated after a time, and the moisture disappeared, they called it the "dry dressing." It was underneath this that they secured union by first intention. They boasted of their linear cicatrices, which they said could scarcely be noticed, indicating that the healing process had evidently been quite perfect and undisturbed.

We know these facts about the mediaeval surgeons, not from any vague tradition nor from any long subsequent writing about them, for it would be very easy to think that some one had perhaps devoted himself to romancing about these old teachers in the university medical schools in the light of modern knowledge. We have the textbooks of surgery written by more than a dozen of these men. Many of them were printed during the first and second generation of printing and were considered very valuable by the surgeons of the Renaissance period. Many more of them have been issued in modern editions with annotations by men who have

devoted themselves to the study of this magnificent era of surgery.

We can scarcely believe it because our surgery and good hospitals have developed in the last generation, that is, since Lister's time in the seventies of the nineteenth century. Owing to our sanitary progress a generation now represents more than fifty years. Before that, surgery had sunk to so low an ebb as to be almost a disgrace. The head surgeon of the great Munich Hospital, containing some 5,000 beds, declared, at the beginning of 1870, that he would never operate in that hospital again. No wonder! His operating mortality for the preceding year had been 79 per cent; that is to say, four out of five of all the patients operated on, died.

This experience was not exceptional, though it probably represented a bad eminence in hospital failure to benefit patients. Everywhere throughout the world hospitals had extremely high mortality just about this time. Amputations were supremely dangerous. More than one out of two amputations of the knee were followed by death, and three out of four amputations at the hip joint. A patient might come in for an operation on a mutilated finger and die of septicemia. Erysipelas was nearly always in the wards, hospital gangrene frequently occurred, pyemia and septicemia were rampant at all times. It was no wonder that the poor dreaded hospitals so much, and that we still find some of that traditional dread of hospitals, at least among older people. Even maternity hospitals had a death rate of ten to twenty per cent just before Lister's time, and it was more dangerous for a poor woman to have a baby in a hospital than to have an attack of typhoid fever.

Most of us are inclined to think that if the hospitals were that bad about the middle of the nineteenth century they must have been awful in the eighteenth century and probably unspeakable in the seventeenth and sixteenth; as for the hospitals of the preceding centuries, the less said about them the better. There is no such progression, however, to be found in the actual historical facts. On the contrary, the middle of the nineteenth century represents the worst period in the history of hospitals of which we have any knowledge. Miss Nutting and Miss Dock, in their History of Nursing, have a chapter near the end of their first volume, called the Dark Period of Nursing. Ordinarily it would be assumed that this must have occurred some time in the dark ages, but the first paragraph of that chapter runs as follows:

"It is commonly agreed that the darkest known period in the history of nursing was that from the latter part of the seventeenth up to the middle of the nineteenth century. During this time the condition of the nursing art, the well-being of the patient, and the status of the nurse all sank to an indescribably low level of degradation."

These conditions grew progressively worse until finally they reached a pass beyond which apparently they could not go any lower, and men were stirred deeply to bring about reforms. As a consequence we have the very happy conditions that exist at the present time.

Miss Nutting and Miss Dock have particularly emphasized, however, that while the hospitals of less than a century ago were the worst that mankind has ever known, the hospitals of the older time were really wonderful in their arrangements for the care of the ailing in such ways as would give them the best possible opportunity for recovery. This was especially true of that period in which Mondeville represents a culmination of the most expert surgical teaching and care for his patients. When one understands that, it is much easier to comprehend in Mondeville's textbook on surgery the meaning of his passages with regard to the nurse.

The great surgeons of this time have told us very clearly what they thought should be the character of the surgeon, and Mondeville particularly had a very high ideal in this regard. No wonder, then, that he expected so much of the other medical attendants or assistants, nurses, as we would call them. Mondeville said:

"A surgeon who wishes to operate regularly ought first for a long time to frequent places in which skilled surgeons operate often, and he ought to pay careful attention to their operations and commit their technique to memory. Then he ought to associate himself with them in doing operations. A man cannot be a good surgeon unless he knows both the art and science of medicine, and especially anatomy. The characteristics of a good surgeon are that he be moderately bold, not given to disputations before those who do not know medicine, operate with foresight and wisdom, not beginning dangerous operations until he has provided himself with everything necessary for lessening the danger. He should have well shaped members, especially hands with long, slender fingers, mobile and not tremulous, and with all his members strong and healthy so that he may perform all the good operations without disturbance of mind. He must be highly moral, care for the poor for God's sake, see that he makes himself well paid by the rich, should comfort his patients by pleasant discourse, and always accede to their requests if these do not interfere with the cure of the disease."

Mondeville did not hesitate to declare that the surgeon ought to be both physician and surgeon. Such a man had opportunity for the study of the internal organs suffering from various diseases much more than the physician who did not practice surgery, and should take full advantage of it. Both the distinguished Regius Professors of medicine at Oxford and Cambridge, Osler and Albutt, have within the past few years, just before the lamented Osler's death, insisted that the physician ought oftener to be present at the operations performed on patients in whom he had made the diagnosis. Mondeville as well as other surgeons of his time felt this, and therefore he ventures to say:

"It follows from this that the perfect surgeon is more than the perfect physician, and that while he must know medicine he must in addition know his handicraft."

Chirurgery, chirurgia as they called it in the old Latin, surgery as the word has come to be used in the modern day, meant, according to etymology, handwork, but Mondeville thought the surgeon should be ever so much more than a hand worker, and therefore he asked that the surgeon's assistants be skilled, tactful attendants who could be depended on to call out and maintain all the patient's naturally resistive vitality and keep him in the best possible mood for the exertion of the least tendency he might have to get better.

Here we have expressed as simply and straightforwardly as it could be, the most thoroughgoing recognition of the relation of the nurse, or the assistant, to the physician. Her principal business is to carry out the surgeon's orders as regards the care of the wound but her duties are much more than this. She must keep the patient in as good condition of mind and body as possible. She must see that the diet is ample and satisfactory to the patient, and she must take means to secure the appetizing eating of sufficient food in the proper amount to maintain nutrition. She must do all that lies in her power to make patients as comfortable as they can be, and with this aim in view must use her experience to secure such accessories for the sick room as will help remove the tedium of confinement to bed or to the house. This medieval surgeon mentions music and other types of recreation, evidently feeling that his assistants should make it their business to provide them for the patients.

But it is not only the patient's body, it is his mind as well that they must care for. They must remove all sources of worry and anxiety and for this purpose must maintain an atmosphere of peace and happiness in the sick room. Mondeville warned of the danger of relatives dropping hints of the patient's condition, and of the necessity for avoiding anything of this kind. Undoubtedly he must often have warned his own nurses of the disadvantages likely to accrue to the patient from any lack of tact and thoughtfulness on their part in this matter. He was condensing his instructions into a few brief paragraphs for incorporation with his textbook on surgery. Had he been writing *in extenso* for the nurses themselves, he would doubtless have amplified his hints into what is now called psychotherapy for nurses. He wanted his patients to be happy and hearty of mind and body just as far as their ailment would allow, and he expected his nurses to contribute to this in so far as they were able.

It seems very unfortunate that the place of the nurse was not appreciated more in the older time, and quite lamentable that the movement for the instruction of nurses thus originated should not have gained a foothold and gone on developing. Just this same sad feature must be conceded, however, as regards the hospitals and the surgery of those days. Many of the best traits of these institutions were lost sight of in succeeding centuries, and there was a distinct decadence in both of them which continued to carry them backward until the middle of the nineteenth century, when, in the course of half a generation, anesthesia, nursing, and antisepsis all came back as important auxiliaries for the surgeon and as marvelous benefits for mankind. Why there should have been this decadence is indeed hard to understand. The mystery of human history is not progress, but the fact that the good work men have done is so often forgotten or at least lost sight of for a time. Succeeding generations have to begin over again for themselves, doing what seems to them absolutely new work.

Doubtless if we knew the details, there were earlier recognitions of the place of the nurse and her value as an auxiliary to the physician and the surgeon. The magnificent temple hospitals of the Egyptians and the Greeks, long before the Christian era, surely recognized this power of the trained attendant to put the patient's mind in as favorable a condition as possible to accept suggestions for his improvement.

At the beginning of my textbook on Psychotherapy I told the story of the great temple hospital at Epidaurus which was really a health resort. This provided nearly every form of mental occupation. There was a theater seating more than 10,000 people, a stadium seating more than 12,000 for athletic events, a hippodrome for all sorts of amusements in which animals share. There were walks through the wooded grounds, sheltered paths for inclement weather, tunnels for passage from one building to another, and the priests and attendants in the temples made it their business to minister to the minds as well as to the bodies of patients.

To Our Queen

Dear Mother of our Lord, so sweet, so fair,
Queen among the angels, Heaven's delight,
Enshrined in atmosphere of radiant light
Give listening ear to each heart's fervent prayer
Ascending as rich perfume through the air,
Blending with the rainbow clouds, to meet
In chains of golden thought, thy rosary complete.

What hidden beauties Love unfolds, so rare!
Dream visions, veiling soft the azure blue.
Each mystery of thy precious charm we love,
And fain our deep devotion we would prove.
Our tears as Duty's jewels, glistening dew
Soft shining on thy wreath of roseate hue,
The Spirit's tribute, shown to thee above.

—Mabel Adams Ayer.

Planning Hospitals by Measured Circulation

Perry W. Swern, of Berlin and Swern, Architects for "Bacon Plan Hospitals."

THERE comes a period in the progressive development of every worth-while enterprise when a halt is necessary for a complete reorganization of the composing units. Hospitals are entering this stage; and, before any more real progress can be made, there must be a "reversion to type" and a complete elimination of all the old prejudices and complications that have been collecting for the last fifty years. A reason, based on modern methods, must be established for everything. We cannot carry over arrangements that were very good in their time, but are now totally inadequate for the demands of today.

All of the industries and commercial enterprises have gone through this period of regeneration. If any of our forefathers could return and watch the present systems of production, their surprise would be far greater than that of Rip Van Winkle. Competition has provided the urge for the imagination to develop every possible means for speeding up in an endeavor to obtain the necessities and luxuries of life with a minimum expenditure of human effort. Whether or not this is a healthful procedure for society, remains to be seen. History repeats itself, we know, but we find in the annals of man no records of the effects of a similar mechanical age.

Hospitals, having a humanitarian foundation for their service, and an ability to enlist the sentimental side of man in philanthropy, have been able to a great extent to keep outside of this sweeping current of efficient production. For a while this was a real advantage because it allowed others to do the pioneering. Now we find hospitals competing, not so much among themselves, but with other systems, which can offer better working conditions for their employees. This very fact sounds the call, and whether they wish it or not, hospitals must follow if they are to go forward, or even continue. Intelligent individuals cannot be expected to select a life work where it is extremely evident that their efforts and energy are grossly wasted. Every hospital executive has seen this handwriting on the wall and has racked his brain to devise ways and means of keeping his head above water. In many cases it has been done at the expense of his colleagues, and not truly by betterment of the whole group.

Selfishness, prejudice, and even advocacy have no weight in what must take place—there must be a logical reason for every procedure. The problem must be attacked open-mindedly. No individual can feel that he is the chosen son and that his judgment is to be forced on every one else. This regeneration cannot be accomplished by any scheme of remodeling the present fabric of hospital routine. It must start from the cold facts derived from the frank question—What is hospital service? Even to define this the mind must be cleared of ideas resulting from observation or experience. Human nature prompts the individual to defend his accustomed ways, and therefore to define hospital service according to his habitual methods, with certain minor additions or deductions.

This is the first of several articles discussing scientific principles in the planning and construction of hospitals. Subsequent articles will take up important features in the planning of various departments of the hospital. The author is a Fellow of the American Institute of Architects, and writes with long experience as a designer of hospitals.—Editor.

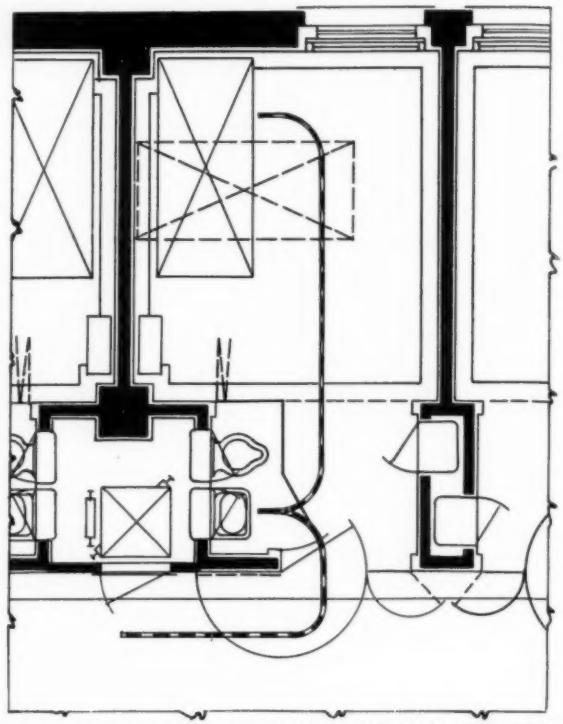


FIG. 1. PRIVATE ROOM. GERMAN EVANGELICAL HOSPITAL, CHICAGO, ILLINOIS.

If only a small nucleus of hospital people will clear the decks for action and willingly submit their ideas to a common boiling pot, there can be formulated a definition of hospital service that will be acceptable to the public, the medical and nursing professions, and other hospital workers; a real start will be made, and we can actually begin to create individual institutions that will give such service.

Among many varied ideas about hospital service, the one that seems best is a composite from several able thinkers and can be set down as follows:

Hospital service provides complete facilities for the care, comfort, and recovery of the sick, so flexible that the service can be varied to obtain the best adaptation for the individual and the community served, rendered at a cost comparable with the energy and material expended, and within the means of the patients; and further, the facilities are so organized

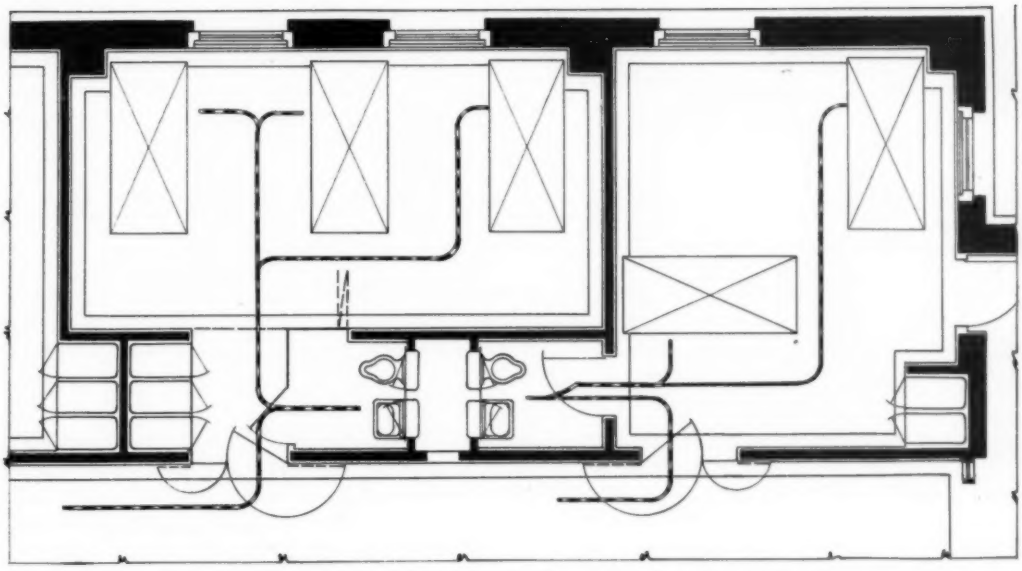


FIG. 2. TWO AND THREE BED WARD UNIT. HERMANN HOSPITAL, HOUSTON, TEXAS.

that the service will perpetuate itself by progressive teaching and research within and without.

Having for a slogan a clear conception of hospital service and a comprehensive survey of the particular community, past, present, and future, it is not very difficult to establish a hospital policy for each hospital. When this is done we are brought to the stage of providing the physical means necessary for the service required by the policy that has been established.

Hospital service must be taken to pieces and all its parts set down. The relative importance of the subdivisions cannot be accurately established, for every policy will color them differently.

The patient normally goes through almost all this service during his stay, receiving a variable amount from each, depending upon the case. With some of the service he comes in direct contact, and with part only the product of the department reaches him. But in all cases there is constant circulation. Either the patient himself is being moved, or the nurses, interns, or doctors are constantly on the go; and circulating in, around, and among them come the products of the service and accessory departments. The hospital is perpetual motion defined. It has delirium tremens, when comparing its motion studies with those of any other business. There are peak loads with heavy pressure, and emergency spasms to be expected at any minute, all of which, in a year's total, creates thousands of miles

Subdivision of Hospital Service

1. Care of the Sick
   - Floor Nursing
   - Group Nursing
   - Special Nursing
   - Interns
2. Comfort of the Sick
   - Foods
     - Preparation
     - Service
   - Agreeable Surroundings
     - Physical Comforts
       - Equipment and Arrangement
       - Linens
       - Safety
     - Mental Comforts
       - Color
       - Individual-Equipment
       - Quiet
   - Companionship
3. Recovery and Progress of the Sick
   - Accessory Departments
     - Operating
     - Obstetrical
     - X-Ray
     - Laboratory
     - Therapy
   - Dietary Department
     - Balanced Meals
     - Special Trays
     - Health of Personnel
   - Out-Patients' Department
     - Diagnosis
     - Treatment
     - Dispensary
4. Teaching
   - Nurses
     - Training School
     - Dietitians
     - Technicians
   - Interns
   - Community
     - Social Service
     - Health Center
     - Free Clinics
5. Records and Research
   - Files
     - Case Records
     - Administration Records
   - Prestige
   - Reports
   - Inspiration

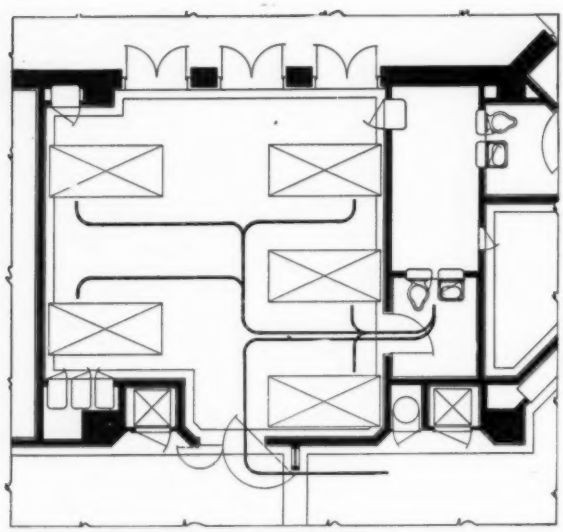


FIG. 3. FIVE-BED WARD UNIT, HERMANN HOSPITAL, HOUSTON, TEXAS.

of traveling—the one largest and most common thing done in a hospital.

The commercial efficiency of a hospital is directly proportional to the amount of traveling required in producing a definite amount of service. No matter how exceptionally efficient the nursing itself, or all the professional phase of the service may be, in the final analysis the amount of tramping required to put it across is an eating fire that consumes personal energy, supplies, and equipment. It is for this reason that a system of planning hospitals by "Measured Circulation" has been developed; all with the idea of preserving in hospital service everything that is at all likely to help the patients but squeezing out every foot of unnecessary travel, and eliminating every motion that is non-essential.

To study and measure the circulation correctly, we must further take apart the various elements of hospital service, discuss each feature, and put them together in such a way as to develop some "rules of thumb" that can be used as measuring sticks of plan efficiency.

The typical nursing unit is most essential for the reason that a corridor ten feet longer than it need be causes miles of unnecessary travel in a very short period of time. The nursing unit is a group of patients normally assembled together and placed under the care of a floor supervisor and her staff. The number of patients per unit is dependent somewhat on the service, the class of patients, and the physical arrangements of the floor plan. A study of floor nursing indicates that from 35 to 40 patients per unit give sufficient work to keep the nursing personnel busy but not overworked. This range may seem high to those who are accustomed to old hospitals, but in a plan developed on the principles of "Measured Circulation," there are not so many nursing miles per day for 35 patients as there would be for 25 patients in the old type of plan.

The nursing unit is made up of a group of patient units which may vary greatly in themselves, depending on the hospital policy, which takes into account the type of patients. The patient units may be private rooms, semi-private rooms (two beds), small wards (four to six beds), or even larger wards, and much to every one's surprise the nursing miles required are in inverse ratio to the degree of decentralization of the nursing utilities. In other words, it actually requires fewer nursing miles to take care of 35 patients in private rooms with individual utilities, than it does to nurse the same number in wards with concentrated utilities. This is accounted for by the back travel in ward type plans.

The nurse is the volume producer when it comes to measuring the part of hospital service which each class of worker contributes, and therefore a very careful study of her duties is most essential. The nurse is to the hospital what the skilled mechanic is to the industry, and to procure efficiency, every minute of her time should be devoted to doing the things her training has equipped her to handle with precision and dispatch, and thus make use of her education to best advantage. If a shop foreman should draw off his machinists to move around his castings every day, he would soon be dismissed. Likewise in hospitals, asking nurses to do things not actually nursing but in the class of maid service or kitchen help, is wasteful of hospital energy. The division line between what is nursing and what is not, is hard to draw, since all contact with patients involves some element of nursing and any service that is helpful to the patient physically or mentally cannot be delegated to inferior help unless it is rightly done.

From the viewpoint of the outsider looking in, unbiased by prejudice, we would say that nursing service can be divided into two big classes: one requires the nurse as a worker under nurse supervision; the other can use unskilled labor and only requires for success, nurse supervision. The first constitutes principally that part of floor nursing which deals with the technical skill and adaptability of the nurse in the varying needs of the patients. It is that part of floor nursing which

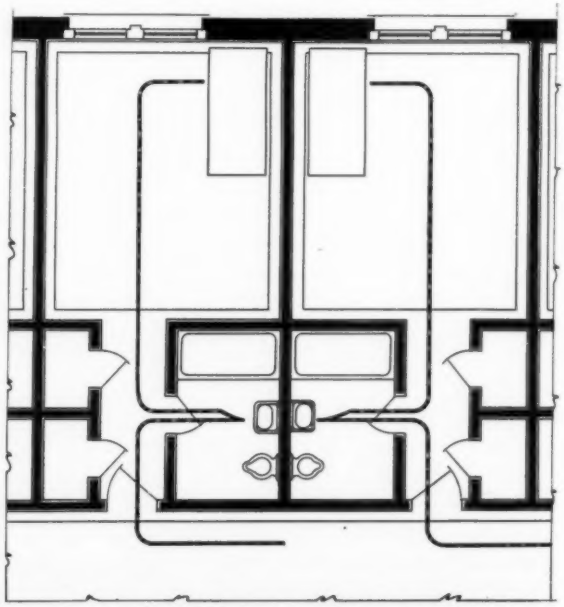


FIG. 4. PRIVATE ROOM. ST. MARY'S HOSPITAL, ROCHESTER, MINN.

requires decisions and actions based on the medical knowledge of the profession. It is that part of nursing which anticipates, and brings comfort and confidence to the patient by the mere presence of an intelligent and watchful personality.

The other part includes all the duties that do not depend on nursing education, and that cannot or should not be done with the patients, and are more or less similar and fall into the quantity production class, regardless of the type of case or the sex of the patient.

To accomplish results efficiently for the first class, the physical facilities must be as completely decentralized as possible; and to accomplish the same results for the other class, centralization is the key. In the past almost the reverse has been the practice. We find a common utility room intended to serve patients hundreds of feet away, necessitating a city block or more of travel to answer and fulfil the individual requirements of each patient, and we find linen rooms placed in various corners of buildings that could not be otherwise used.

A few examples will illustrate more completely the parts of nursing which fall into these two classes:

To be executed with individual utilities:	To be executed with concentrated utilities:
Drinks of water	Preparation and supervision of food
Bedpan service	Handling linen and household supplies
Bathing and toilet	Drug and solution preparation
Hot or cold dressings	Sterilization

Briefly, the reason for this is that the services in the first group are dependent upon the individual patient as to the time of requirement. The establishment of a rigid routine for these attentions is impossible; the facilities must be on hand at any minute. The second group, on the contrary, can be programmed and run on a production basis without fretting the patients in any way; in fact, patients expect these services at appointed hours and become irritated if they are delayed or hurried.

It is the concensus of opinion that nursing in a private room is ideal for the vast majority of hospital work. The system of "Measured Circulation" plays its important part in accomplishing this without exceeding the bounds of available capital, and at the same time giving the service for a price that is popular. With nursing classified as above, it is not hard to devise physical arrangements that will allow such service.

The cost to build and operate is directly dependent on the cubic contents and the miles of travel required to execute the service. Hence it becomes necessary to conceive a patient's unit that is compact, yet roomy, flexible and not in any way cramped as to service; one that has all the conveniences and needs for individual nursing and still has a small contents and a minimum of width. The contents affects mostly the initial cost and maintenance; the unit width affects the cost of service. A small "nursing radius" is absolutely essential if the floor nursing is to be efficient. While six inches more or less in the width of the typical room seem of small importance, they really are very vital. In a group of ten rooms on one side of a corridor, such a six-inch increment means a two and one-half foot longer nursing radius, and this difference in radius, times the total calls answered each day, spells miles of wasted time and energy; briefly, this means more nurses to give the same service, or poorer service with the same number of nurses. The patients must be kept close to the station, without any auxiliary rooms intervening.

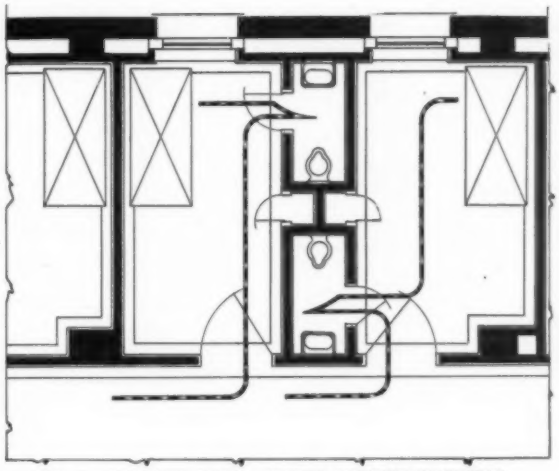


FIG. 5. PRIVATE ROOM. FIFTH AVENUE HOSPITAL, NEW YORK CITY.

The desirable nursing unit is compact, with a small radius, balanced in at least two directions from the station. If three corridors radiating from the nursing stations are possible the nursing will be even more efficient.

	Fig. 1 Private	Fig. 2 (2-bed)	Fig. 2 (3-bed)	Fig. 3 (5-bed)	Fig. 4 Private	Fig. 5 Private
Unit Area	210 sq. ft.	172 sq. ft.	130 sq. ft.	116 sq. ft.	385 sq. ft.	210 sq. ft.
Area in patient space	137 sq. ft.	111 sq. ft.	90 sq. ft.	85 sq. ft.	237 sq. ft.	131 sq. ft.
Area efficiency	65%	64%	69%	73%	62%	62%
Feet of travel to answer one call	55 ft.	52 ft.	62 ft.	82 ft.	94 ft.	60 ft.

Some examples and statistics of the physical factors of several common patient units will be interesting:

Fig. 1 is the typical private room with individual utilities as used in the "Bacon Plan Hospitals."

Fig. 2 is an arrangement of two and three-bed wards where each ward has separate utilities. (Hermann Hospital, Houston, Texas.)

Fig. 3 is a five-bed ward with separate utilities for the ward. (Hermann Hospital, Houston, Texas.)

Fig. 4 is another arrangement of private room with utilities and an added bath for each room. (St. Mary's Hospital, Rochester, Minn.)

Fig. 5 is an arrangement of private room with the utilities between the rooms. (Fifth Avenue Hospital, New York.)

The Soul of the Hospital

Edward F. Garesché, S. J.

The management of a Catholic hospital in the United States from a financial viewpoint has come to be a very complicated and difficult work indeed. A modern hospital has from one viewpoint the complexity and expensiveness of a large hotel, and all the departments required to care for the lodging and feeding of many individuals must be developed therein. But the guests cared for in a hospital are, for the most part, much more dependent and in need of ministrations than the inmates of a hotel and therefore to the hotel problems, as they may be called, of the hospital manager, are added many other vexatious cares tending to promote the welfare, safety, and comfort of the patients.

Add to this the special features of a hospital, each with its own items of expense for equipment and management, the nurses' home, the laboratory, the operating room, the diet kitchens, the x-ray department, the clinics, and we multiply occasions of expense. Thus the ordinary and every-day expenditures of a hospital mount up into figures which would surprise and startle one not familiar with the requirements and demands of modern hospital service.

Many of these items of expenditure are necessary and irreducible. Supposing that those who do the buying of food for the hospital, secure first rate materials at the best prices, they have done all that can be expected of them. Suppose that waste is cut down to a minimum, while service is left at a maximum, and what more can be demanded even from the most careful manager? Those in charge of a hospital, therefore, while desiring to be as economical as possible, look with equanimity on totals of expenditure for food, coal, supplies, and other necessaries which would startle the uninitiated. They feel that these things are necessary and that the money is well spent. Even from a material standpoint, what is so expended is only invested and brings good returns in service and satisfaction to the patients, securing their future patronage and support and their present gratitude and payment.

No sensible person in charge of a hospital would try to economize by cutting down the price paid for food until only inferior materials could be secured, and thus give the patients a poor and unsatisfactory diet. Nor would any hospital official think of refusing to pay for good coal and economizing by shutting down the furnaces or feeding them cheap slack, incapable of making a good fire to heat the premises. Neither would he dream of trying to induce the help to work without salaries, or refusing to pay them what they needed to live on. To act in such a way would be to court disaster. All such disbursements of money are expenditures which pay.

These things are obvious enough and we only mention them to point a further reflection. If it is apparent that these necessary expenses for the care of the body of the patient and for the warming and cleaning of the hospital, are expenditures worth while for the returns they bring in warmth, sanitation, nourishment, and general welfare, it is no less true that there are other legitimate items of expense, no less useful and profitable to the hospital, which are sometimes curiously overlooked and neglected even by prudent hospital managers.

A hospital, like an individual, may be said to have its body and its soul. The body of the work is made up of its exterior and material equipment and environment. The great building, competently outfitted, kept warm, and clean and in good repair; the food, the coal, the furnishings, all these represent the bodily parts, so to say, of hospital work. The buildings of a hospital are its clothing, a raiment at once beautiful and useful which gives the hospital outward distinction and keeps its material activities safely sheltered and housed. All the care and expense involved in keeping the hospital activities provided with the material things needed for their complete welfare pertain to the bodily care of the institution. Like all important material interests, they are worth what is expended on them, provided economy and frugality go hand in hand with a wise liberality in giving everything that is required.

But the hospital has also its soul, unseen, subtle, not making insistent demands for tangible supplies and conveniences and equipment, as does the material part, but none the less real, important, even essential for all that. The soul of the hospital is the spirit that pervades it, the morale of its workers, their intellectual and spiritual condition and attitude, the motives which impel them, the attitude they take toward their work. This soul of the hospital gives life to all its material functions. The quality of its service, its influence on the patient, its capacity for restoring him to health of body and mind and soul, are dependent on the spirit which pervades its activities, on the attitude of its staff and its workers, the intellectual and spiritual conditions which prevail within its walls.

On those elements of the hospital which we have called its body, on buildings, equipment, supplies; on coal, on food, on instruments, on bedding, on furnishings, what vast sums are spent every year! Who can calculate the total expenses of the members of the Catholic Hospital Association for these things alone? A rough estimate, taking into consideration the fact that there are more than 500 hospitals in its membership, would place the annual expenses for conducting all of these at something like thirty million dollars. In other words, it is probable that between two and three million dollars a month or almost a hundred thousand dollars a day, are required to keep the bodies of the hospitals in that state of efficient healthfulness which their duties toward their patients require.

We have spoken of the mere monetary expense because it is more easily calculated and lends itself to more definite totaling. But almost more impressive than this

huge financial outlay is the vast sum of effort, care, forethought, planning, which goes each year and each month to maintain the body of the hospital in a state of efficient healthfulness. An army of busy workers is constantly occupied in taking care of the body of the hospital. Great contracts are being made, experts are consulted, supplies are being ordered, checked over, made sure of. Worn out or obsolete equipment is being replaced. New buildings are being planned or erected. Energy, thought, calculation are being lavished without stint, as well as money, to make and keep the body of the hospital all that it should be.

Meanwhile what proportion of all these great expenditures of human effort and forethought and of money and labor is being given to the hospital's soul? True, money is not as necessary nor needed in as great sums for the welfare of the soul of the hospital as for its body. Still there are expenditures of energy, thought, money even, which bring as real a return for the welfare of the soul of the hospital, for the intellectual and spiritual profit of its workers and patients, as the effort and expense which are lavished on its body.

One means of promoting the good of the hospital's soul, incalculable in its benefits, is the providing everywhere and lavishly, of excellent reading matter—so plentiful, so free of access, that every one may find it easy to read good books. This is surely an expenditure which pays as truly as does the providing of good food, of good coal, of good bedding. Indeed, books last much longer and serve many more persons than do those material furnishings and provisions. If for every dollar spent on material furnishings a penny were invested in this food of the spirit, our hospitals would every year buy something like three hundred thousand dollars' worth of books, and every hospital in the association would be the richer by some hundreds of volumes. Yet what is one per cent for the soul, or who will say that such an expenditure is not worth while?

Again, the soul of the hospital is nourished and helped by conferences, by lectures, by series of instructions, given by men and women who have become experts in their specialty and who can speak with authority. But these men and women must live from the returns of their labor. If they are lay folk, others may be dependent upon them. If they are religious or priests, their expenses must be paid by offerings. Those in charge of hospitals sometimes complain that it is difficult to obtain the service they wish in regard to lectures and conferences. May it not be that they forget their part in helping toward the support of those who serve them and therefore compel them to go elsewhere with their services? It is a false and mistaken economy to neglect to make the comparatively small offerings which will justify a good and competent speaker to do his part to help the soul of the hospital.

Those who are experienced in the life and management of hospitals will be able upon reflection to make still further application of this fundamental thought concerning the due part of energy, thought, and resources, which should be given to aiding the hospital's soul. How much depends, for example, on the spiritual training of the nurses, on keeping up their instruction in their Catholic faith, on organizing them into a thoroughly fervent and well managed sodality, on giving them at times the benefit of healthful recreation, sociability, entertainment! But for these things some considerable effort is required. Precious time and energy have to be expended. Help has to be enlisted for which perhaps a recompense is due. Should this be a difficulty and an obstacle? Or should not those in charge consider such expenditures, whether of energy, of money or of time, fully justified and even necessary for the sake of the hospital's soul?

Under this same heading of due provision for the welfare of the soul of the hospital, of its morale, of its spirit, of the souls of its workers and its patients, comes all the expense of energy, thought, money, for the sake of better training, higher ideals, a more enlightened policy, better contact with other hospitals and with the best that is being done in hospital work. Here enters in the Catholic Hospital Association with all its connotations and influences, its ideals, its plan for the general good, its interchange of suggestions and encouragements, its striving after higher standards, its constant effort to discover and communicate to all its members what had best be done for the good of the hospital, body and soul.

The benefits of such an association cannot be estimated in terms of mere material achievement. They can not be entirely discovered even by the most careful investigation. Insensibly as well as perceptibly, the members help one another, the association raises standards and introduces ideals, the beneficial influences in hospital life are strengthened and made more effective for the individual hospital. Such movements as that for the standardization of hospitals, have an incalculable advantage when they are promoted through such an association. Individual hospitals might be at sea as to where to begin or what to do. They might desire to take action but not be able to overcome their own inertia. Association gives them definiteness and strength.

The movement for a crusade for vocations now being undertaken, how vital this is to the soul of the hospital, how important for its welfare! If the association had accomplished nothing else, a successful campaign for vocations would more than justify its existence. But this is only one of manifold activities which have a value beyond price. What proportion of its thought, its monetary resources, its energy, should the hospital give to such things? A generous share surely, given readily with uncalculating willingness; a measure filled full and shaken down and overflowing.

Our plea to the superiors of hospitals and to all who have anything to say concerning their policies is to be not only generous but even lavish in everything that concerns the hospital's soul. For the body due provision will surely be made. Everything combines in demanding a liberal policy where there is question of material

equipment and supply. But the soul of the hospital is a more subtle and unobtrusive thing. It neither thirsts nor grows hungry nor falls into outward decay in such a way as to demand food, drink, warmth, repairs. Yet its needs are just as real as, and even more vital than, those of the body. They should be attended to with at least equal diligence and generosity.

Even when these spiritual needs of the hospital are provided for with a most open-handed generosity, the total expenditure of energy, thought, and money given to them will be small indeed compared to the vast sums spent on what we have called the body of the hospital. Three or four per cent for the soul and ninety-six or seven per cent for the body is no great concession to the soul's needs and requirements. Yet is even this proportion now given to the soul's wants as we have explained them?

If those responsible for the care of the hospital are generous almost to a fault in their expenditures for a lavish supply of good reading, for lectures, conferences, inspirational talks, for the nurses and the staff, for recreation of the nurses, for sodalities (and we speak not only of expenditures of money, which will be comparatively slight, but of energy, thought, effort, planning, time), even then how small the total will be compared to the vast sum expended for the body of the hospital! If a generous answer has been made to every appeal and summons of the Catholic Hospital Association, what a small item even this expenditure for the benefit of the hospital's soul will be in comparison with the great total given for those other things, its material needs!

The natural (not supernatural, however,) answer to these reflections might be that other expenses in the hospital are so great, that the calls on energy and time and effort, as well as on money, are so enormous as to leave no surplus for the things we have mentioned as vital to the hospital's soul. "We can not afford," those in charge might answer, "to follow these suggestions; to be lavish in the buying of books; to provide and give recompense for lectures, conferences, inspirational talks; to take the trouble requisite to maintain a fervent and well organized sodality; to support generously the Catholic Hospital Association and its activities. We must economize *somewhere* and the other needs are more insistent."

If any one should make this objection, he should be told that it is false economy and unprofitable as well to stint the soul for the sake of the body. There is wastefulness always, unless the greatest care is taken, in the vast items of hospital expenditure for food, heating, equipment, even for such items as laundering and labor. Economy here is profitable, and when efficiency and justice are safeguarded, is laudable. How many hundreds of thousands of dollars might be saved by greater efficiency in these things, by cooperative buying, by more careful management! But to save money by failing to provide an abundance of Catholic reading, by omitting to give an offering for some useful conference, by grudging the time and effort required to organize a sodality, how little real saving there is in these things and how great a loss! The contemptible figure gained makes no showing at all in the monthly or annual total. But the loss cannot be measured in terms of dollars and cents.

If any one should further add, either in words or thought, that the things we have mentioned as of moment for the soul of the hospital give no trouble by their absence, that no one complains of the absence of good books as they would of the absence of good food, that conference givers are less missed than cooks, and sodalities less wished for than laundries, and that therefore since these things give no trouble by their absence, they are more easily dispensed with and need not give occasion for thought—what shall we answer to this?

Let us recur to that amusing instance of the shrewd old Chinaman who, the Abbe Huc tells us, declared he saw no reason for troubling about his soul, when his body demanded so much attention and his soul never hurt him at all! "Why should we trouble about the soul in the hospital, when its material affairs require so much attention? The hospital grows cold and we must warm it, hungry and we must give it food. It requires attention in its material needs, day by day and hour by hour. But its soul makes no demands, shows no uneasiness, gives no pain. The body of the hospital keeps us constantly busy and takes all the effort we can spare and the money and the time; why should we trouble about the soul?"

Is it possible that there are Catholic hospitals where such pagan principles are observed in practice, where the soul of the hospital and its spiritual and intellectual needs are neglected because of the demands of the body? Are there institutions which economize in education, which save by neglecting ideals, which stint the training of Sisters, the instruction of nurses, the providing of ample supplies of good books, the organization of sodalities, the encouragement of initiative in studies and investigations? If so, then are not such hospitals following out the very reasoning of the old pagan and neglecting the soul for the sake of the body?

"What will it profit a man," says our Lord with searching significance, "if he gain the whole world and suffer the loss of his own soul? Or what shall a man give in exchange for his soul?" That same interrogation might be repeated with deep meaning to every Catholic hospital. Supposing that it were possible while neglecting these higher things of hospital life, the things of the mind and the spirit, to keep up the most splendid buildings, to accumulate the most modern equipment, to provide every material aid for hospital work, to attend carefully to all those things which are part of the body of the hospital. What would this profit if the soul of the hospital were dead? A being whose soul has departed is but a corpse, however magnificently apparelled or sumptuously housed. So is that hospital dead whose soul has departed.

Syphilis and the Duty of the Modern Hospital

Hospital Equipment and Training of Nurses for Handling Syphilitic Patients

James A. Evans, M.D., Assistant Resident in Medicine, Peter Bent Brigham Hospital, Boston, Mass.

SYPHILIS from an economic and social point of view is the source of one of humanity's heaviest losses. There, in a nutshell, lies the responsibility of the Sisters' hospital. The alleviation of one of mankind's greatest woes is an opportunity not to be missed by the Sisterhoods, and cooperation in a nation-wide, post-war movement to help check this scourge of modern civilization is surely not to be avoided by that great Catholic agency best fitted to fight the scarlet plague—the Catholic hospitals.

From a medical standpoint, syphilis is the most interesting of all diseases; as the "great mimicker" it has no rival among clinical teachers. From the patient's point of view it is even more than cancer, the great affliction of mankind, for the cure of which each individual patient willingly goes to any pains and is the most cooperative, provided he is properly instructed as to its consequences.

Hospital's Responsibility to the Community

Many hospitals, and especially Sisters' hospitals, are reluctant to handle syphilitics. This applies especially to syphilis in the infectious stages. First, let us take issue with the narrow, but perhaps natural, repugnance of our fine-minded religious to the handling of this class of patients. Has such a repugnance really a moral argument in its support? Does the church refuse spiritual healing in the confessional to such sinners? Then why should Catholic hospitals refuse the best of medical care for the healing of their bodies? Secondly, is there any moral support for the neglect of this class of patients when we stop to consider the harm that may result in the innocent community from the possible spread of their infection?

It is very commonly assumed that venereal patients are alone responsible for their own condition and therefore the least deserving of all patients to a hospital's consideration. Even granting this argument, we must look farther ahead; we must consider the social aspect of the disease; for no disease, not even tuberculosis, is of greater import in the physical suffering, the moral, and the financial losses it inflicts upon the innocent community. First, there is the contact spread of infection, both innocent and salacious; secondly, the hereditary spread, most unfortunate of all aspects of the dread disease. Syphilis is not only a disease peculiar to mankind alone; it is unique among humanity's ills as the only hereditary disease. It is very likely, when innocent wives, hereditary luetics, and innocent personal-contact infections are considered, that twenty-five per cent of syphilis is innocently acquired. Another important social aspect of the disease is the economic loss to taxpayers, supporting ten to twenty-five per cent of our insane asylum population, the direct result of syphilis.

Considered from this point of view, it becomes a moral and social obligation on the part of the hospital to protect the community from the spread of an infection which, by very conservative statistics, is present in five per cent of the population. Thus certain of the leading hospitals of the country consider it their bounden duty not only to accept luetic patients in the primary and secondary stages of the malady, but to keep them in the hospital by persuasion if possible, or by force if necessary, in those states where the law allows, for intensive treatment until all infectious lesions have disappeared. An exceedingly fortunate circumstance also pleads in favor of this policy from the patient's point of view. It is in the early infectious stages of syphilis that the disease is most amenable to cure, and by intensive therapy in the hospital the patient is most likely to obtain treatment adequate to abort his infection. When the patient is kept in the hospital there is no question about his receiving a sufficient number of injections to sterilize his infectious lesions. Therefore we make an urgent appeal to doctors to send their infectious luetic patients to the hospital for the most satisfactory assurance of early intensive treatment; and we appeal to our hospitals to admit willingly such patients until the infectious stage is passed. In the vast majority of cases a stay of two to three weeks suffices. The infectious lesions disappear like magic after four to six injections of arsphenamine.

If the financial resources of the patient do not allow a private room there is no danger in admitting him to the general ward, provided usual typhoid precautions are taken. The admittance of infectious patients to the general wards is a constant practice here at the Peter Bent Brigham Hospital, and of most large general hospitals.

Such precautions consist in the use of a personal set of eating utensils boiled each time after using, the careful sterilizing of all excreta, the forbidding of toilet privileges, and a personal urinal and bedpan for such patients. Beside the bed is a basin of bichloride solution, in which are kept a pair of rubber gloves, to be used by the nurse in all duties pertaining to the care of the patient or the handling of his personal effects, such as eating utensils, tooth-brush, etc. The nurse should wear a gown which may hang wrong side out near the patient's bed. The patient is either kept in his bed or may sit in a chair in his own corner of the ward. Under no conditions may he mingle with the other patients.

It is of great comfort to doctors and nurses to know that the spirocheta pallida, or germ of syphilis, is a very delicate organism, and that a simple soap and water scrubbing will effectually kill spirochetes on

the skin. In the wards of the Massachusetts General Hospital and the Peter Bent Brigham Hospital, infection of hospital personnel or other patients has never occurred under these precautions.

In our opinion, then, for the good of both the patient and the community, infectious lues is best treated by hospitalization, in the same way all are agreed typhoid is best handled.

First Intravenous Treatment

In many non-infectious cases about to receive the first intravenous treatment, where the doctor suspects the likelihood of a reaction, it is preferable to give the first treatment in a hospital where all resources are at hand for observation and emergency measures. Chills, fever, and gastro-intestinal upsets are common after-effects, and for the patient's own good he will be better off where competent help is easily available. Certainly no hospital should refuse admittance to such cases.

Cardiac Syphilis

Another fairly large class of luetics whom it is often found advisable to hospitalize are those with syphilitic aortitis, aneurysm, and aortic regurgitation, and those rarer forms of cardiac lues: viz., syphilitic endocarditis and myocarditis. Hospitalization is most urgent in those cases presenting symptoms of angina pectoris and dyspnea after slight exertion, or decompensation, for the all important bed rest and building up of cardiac reserve. Cardiac rest is always preferable in a hospital, where life moves in an ordered routine and where efficient nursing is designed to spare the patient all forms of exertion.

The specific treatment of such cases should always be most cautiously undertaken, particularly at the onset, and in many instances only when the patient is at rest for a prolonged period in bed. It is especially in this class of patients that arsphenamine has acquired a dangerous reputation, but clinical experience is showing that intravenous treatment offers great relief to many of these patients, especially those afflicted with the angina of syphilitic aortitis. It is advisable to mercurialize such cases well, over a period of two to four weeks perhaps, before admitting to the hospital. Then hospitalize for a long rest in bed, and while in the hospital after the first week of rest, cautiously begin intravenous therapy with small doses of arsphenamine. We have seen one such patient with a visibly pulsating aneurysm, with marked angina and dyspnea, return to work as a freight handler.

Cases for Lumbar Puncture

The value of early lumbar puncture in all cases of syphilis is now generally recognized. Cases past the secondary stage should have immediate lumbar puncture when first treatment is undertaken by the doctor. Primary and secondary luetics should be punctured before they are discharged from treatment. All lumbar punctures should be done in the hospital and the patient should remain over night in bed during the entire stay. This treatment will eliminate many severe headaches.

For lumbar punctures the hospital should supply the necessary lumbar-puncture needles and two sterile test tubes. Its laboratory should be equipped with a microscope with a mechanical field, a counting chamber, glacial acetic acid, and saturated ammonium sulphate. The laboratory technician should be acquainted with the method of doing a spinal fluid cell count and differential, and should know how to make the simple test for spinal fluid globulin. The glacial acetic acid is to rinse out a blood counting pipette before filling it with spinal fluid and transferring a drop to the counting chamber. This procedure will hemolyze any red blood cells present before making the cell count. The saturated ammonium sulphate is used for the globulin test. The technique for this test is to be found in any laboratory manual.

The hospital laboratory should take upon itself the responsibility of seeing that the spinal fluid is sent to a Wassermann laboratory for Wassermann and colloidal gold tests. The specimens for Wassermann should go preferably to a laboratory that runs the tests on different titers of spinal fluid each time. Reporting the various titers of spinal fluid between 0.1 cc. and 2.0 cc. necessary to give a positive Wassermann reaction, aids the clinician greatly to determine the severity of involvement of the central nervous systems, often a guess as to the activity of the disease in the nervous system, and to follow by repeated punctures the effect of his treatment. At least 4 cc. of spinal fluid should be sent to the Wassermann laboratory for complement fixation and colloidal gold tests.

The nurse prepares the patient for lumbar puncture in bed if necessary, but preferably on a hard, unyielding surface such as an examining table. The patient is made to lie on either side with his lumbar region at the edge of the table, his knees drawn up under his chin as far as possible and his head and shoulders bowed well forward toward his knees. With the patient in this position a small rubber sheet is shoved beneath his lumbar region. The doctor indents the last three intraspinous spaces with his thumb-nail, after which the nurse applies two soap and water scrubs, followed by alcohol scrub or dab of iodine to the region indicated by the thumb-nail marks. Then the patient is draped with three sterile towels, one beneath and the other two arranged triangularly over his back to expose only the lumbar region. The doctor performs his puncture and the nurse holds ready the two sterile test tubes to catch the fluid, taking care not to touch the end of the needle with the tip of the test tube. These test tubes should be very clean and preferably corked rather than plugged with cotton, to avoid debris in the microscopic field when the cell count is performed. After the needle is removed a bit of flexible colloidion closes the perforation in the skin.

Central Nervous System Syphilis

The group of central nervous system syphilitics has always been the largest class of luetics in our hospitals.

I make exception of the paretics who most often find their way into insane hospitals. Except the frank tabetics and paretics, many of these cases are often admitted under the guise of other tentative diagnoses: acute surgical abdomens, for tabetic crises; cerebral hemorrhage, for syphilitic cerebral vascular disease; brain tumor, tuberculous or meningococcic meningitis, for syphilitic meningitis; various spinal cord degenerative diseases, for syphilitic spinal meningitis or syphilitic myelitis, etc. The diagnosis is then only made on lumbar puncture, which should always be done in the hospital. Many of these cases are desperately sick and helpless and demand hospital treatment. Most of them require hospital facilities for complete scientific diagnosis. In many cases consultations by various members of the staff are necessary. Thus the genito-urinary specialist may be called in for his advice in bladder complications so common in spinal syphilis; the ophthamologist's expert opinion may be needed on the eye grounds; the x-ray department may be called upon for a stereo of the skull; the neurological surgeon may be needed for his advice in rare cases simulating brain tumor or on the advisability of rare cases demanding decompression for increased intracranial pressure or posterior column resection for root pains. The surgical staff may be necessary to rule out acute abdominal disease in cases of tabetic crises. All cases of central nervous system lues should receive complete neurological examinations with the possible exception of frank tabetics. Such an examination is certainly best performed in the hospital, where continued and daily observation of the progress of signs and symptoms is best carried out.

There is one type of syphilitic, above all others, which it becomes imperative to hospitalize. These are the acute vascular accidents, cases of acute syphilitic meningitis, and patients with acute cerebral or spinal parenchymatous involvement. Such patients are often rendered more or less helpless and demand careful nursing and the constant care of the hospital interns. They are often paralyzed, bedridden, sometimes incontinent of feces or urine or both, often demand catheterization for a time, and are all habitually constipated, demanding frequent enemas and administration of cathartics.

But most of all is it necessary to send such cases into the hospital for active, specific treatment. It is conceivable that the nursing problem with these patients might be successfully met, and the diagnosis, even including the lumbar puncture, be successfully completed in the patient's home; but modern treatment of central nervous system syphilis demands hospitalization. Reactions to intravenous treatment are more common in this group; more intensive treatment with consequent quicker relief of symptoms is more safely carried out in the hospital, and intraspinous treatment, so often considered necessary in this group of patients, is only possible in the well-equipped hospital.

Intraspinous Treatment

Most syphilographers are now agreed on the value of intraspinous therapy. To be sure, there is a large group who urgently disclaim its value. Doctor Solomon, in a recent article appearing in the Journal of the American Medical Association, affirms the value of intraspinous therapy in cases that have failed to clear up under prolonged, simple intravenous treatment, combined with mercury and potassium iodide. This is so decidedly our conviction that to gain time at the Peter Bent Brigham Hospital we routinely give practically all our patients with positive spinal fluids a Swift-Ellis intraspinous treatment on the occasion of every other intravenous injection. Hospitalization is a prerequisite to this form of therapy in ambulatory as well as bed-ridden forms of central nervous system syphilis.

Hospital Equipment and Technique

(a) Dark field examination:

Every hospital laboratory should be equipped with a dark field condenser and a small arc lamp to identify the spirochetes of syphilis from the primary and secondary sores. It is to be considered malpractice not to give the patient the benefit of the early positive diagnosis which dark field examination affords. The Wassermann reaction is rarely positive until the primary sore has been present at least two weeks; very often the reaction does not become positive for a month or even two months after the primary sore first makes its appearance. Failure to make a positive diagnosis by dark field examination and the institution of intensive treatment during this period of time would be criminal neglect, for the month or two before the Wassermann becomes positive is the most precious period of the patient's lifetime, a period before the disease becomes generalized and when it is most surely amenable to complete cure.

An old lady of sixty, with a huge, ulcerating tonsil, was admitted to a hospital. Syphilis was suspected but the Wassermann came back negative. There was no dark field condenser in the town, let alone in the hospital, and the tonsil was treated by x-ray for cancer. Another Wassermann two weeks later came back positive. The lesion had been right along a primary chancre of the tonsils, innocently contracted by an old grandmother, probably by kissing her wild son. Two most precious weeks of the right kind of treatment had been lost for want of a dark field examination in this case.

To obtain material for dark field examination the best procedure is as follows: The doctor, nurse, or technician should wear gloves. Serum from the depths of the sore must be obtained as free as possible from blood or pus. For this purpose the sore should be gently scrubbed with soap and water, thus removing surface crusts, pus, etc. Then let one drop of alcohol fall on the raw surface thus exposed. The counter irritation and smarting will cause a plentiful amount of serum to exude from the depths of the sore. A drop of the serum may be sucked into a capillary pipette

with a small rubber bulb at one end for suction, and transferred to a slide. The operation of the dark field apparatus itself is described in all laboratory manuals.

(b) Intramuscular Mercury Injections:

Nurses are often called upon to do the intramuscular mercury injections and for this reason the technique is described as follows: A 2 cc. glass syringe and needles of at least 2 inches in length and preferably of No. 17 caliber are required. The technique employed is as follows: (1) Draw a line perpendicular to the spine from the top of the intergluteal fold. (2) Draw a second line from the posterior iliac spine to the greater tuberosity of the ischium. (3) Choose a site for injection one inch from the intersection of these two lines, preferably in the two outer sections thus formed. Wash the site with soap and water and swab with iodine. (4) Quickly insert into the gluteal muscle, the well sharpened, previously boiled needle. (5) Fill the previously boiled syringe with the desired dose of mercury preparation. In the meantime look for any drop of blood on the end of the inserted needle. If present, it means a vein has been pierced and the site of injection must be slightly altered. (6) Inject the mercury. If pain is caused, choose another site. (7) Now follow up the injection by a small amount of air blown in with the syringe. This will clear the needle and no track of mercury will remain when the needle is withdrawn. (8) Massage the buttock vigorously. Alternate sides are to be chosen for alternate injections.

(c) Intravenous Neo-Arsphenamin and Arsphenamine Injections:

For neo-arsphenamin the very convenient preparations of some of our pharmaceutical houses are much to be preferred. Lacking these, all that is necessary for the hospital to supply is a 20 cc. syringe and suitable needles for intravenous injection.

We consider the old arsphenamine, while more toxic than neo-arsphenamin, to be of definitely greater spirochetocidal power. Therefore in the hospital, where all facilities should be conveniently at hand, the use of this more powerful but more inconveniently administered remedy is to be recommended. A sterile 200 cc. glass-stoppered, graduated cylinder should be provided; larger cylinders are necessary only where more than one patient is being treated at a time. Only water freshly distilled within twelve hours and boiled after distilling, to render it certainly sterile, should be used to dissolve the drug within this cylinder. The water is preferably cool because warm or hot water favors oxidation of the drug; 20 cc. of water is used to each 0.1 gm. of arsphenamine.

After filling the cylinder with slightly less than the desired amount of water, the arsphenamine is poured out of the vial over the water. A sterile bit of wire is useful in breaking up lumps. Ten vigorous shakes of the cylinder will suffice generally to bring most of the drug into solution, and allowing the mixture to stand a few moments will complete the process. Too much shaking is exceedingly dangerous as it mixes the water with air and favors oxidation, which renders the drug poisonous. After the arsphenamine is completely dissolved three drops of fifteen per cent chemically pure Na OH to each 0.1 gm. of arsphenamine are quickly added to the solution. A turbidity immediately becomes manifest. Then slowly add more of the Na OH, drop by drop, carefully counting the drops till the precipitate redissolves and the solution becomes clear again. Now add one-fifth again of the total number of drops already used and one drop extra for good measure. Add more sterile distilled water to bring the solution to the desired amount (30 cc. H_2O to each 0.1 gm. arsphenamine). A sterile gravity container is in readiness hanging from a gravity pole. A sterile glass funnel with a bit of boiled sterile absorbent cotton in its bottom rests in the top of the gravity container. A piece of rubber tubing about four feet in length into which is inserted a glass window, a two-way stop cock with an adaptor at the end of the tubing, leads downward from the gravity container. Fresh rubber tubing should be boiled for thirty minutes in weak potassium or sodium hydroxide solution and tap water run through the tubing over night before it is used in intravenous therapy. This is necessary to avoid febrile reactions. The tubing is boiled again for ten minutes to sterilize it before using.

Now, the solution being ready to administer, the nurse, who should always be present during these treatments, prepares the cubital fossa of the patient with two soap and water scrubs, followed by an alcohol scrub, puts a small rubber sheet covered by a sterile towel beneath the patient's arm, and ties the tourniquet. In the meantime the doctor has been busy pouring about 50 cc. of sterile saline solution through the funnel into the gravity container and running the air out of the tubing. A few bubbles, however, admitted by accident into a vein, will never do any harm. He now inserts his needle into a vein, connects the adaptor to the needle, and allows a small quantity of saline solution to enter the vein, making sure that the needle is cleanly in the vein and that no fluid can leak into the subcutaneous tissues, also that a good flow is established. As soon as these facts are ascertained, the nurse strains the required amount of arsphenamine solution through the funnel with its absorbent cotton, into the gravity container. The injection is followed by more saline.

The third and most important duty of the nurse is to have in readiness a sterile hypodermic syringe with a needle that she is sure will fit the syringe, and a bottle of adrenalin solution ready at hand for instant use in case of a nitroid reaction. Such a reaction is recognized by a sudden flushing, then a cyanosis, rarely a paling of the patient's face, very sudden dyspnoea, cough, great alarm, and distress on the part of the patient. Respirations are very labored, he complains of tightness in his chest, a feeling of great faintness, and he is afraid of approaching death. So is the doctor. The patient must sit up in bed to get his breath, and cries for air. It is one of the most dramatic situations

in the practice of medicine. All the doctor needs to do in such an emergency is to turn quietly to the nurse, say the one word "adrenalin," and have 1 cc. instantly to hand for intramuscular injection, first of 0.5 cc. and later the remainder if necessary. The recovery from such a reaction, if the adrenalin be given in time, is just as dramatic and almost as sudden as the onset. The breeze from an electric fan offers some relief, if only psychic.

(d) Intraspinous Treatment:

I shall describe here only the Swift-Ellis technique, which is rather the accepted standard now of intraspinous therapy. The one important prerequisite piece of hospital equipment for this form of treatment is a good, heavy, high speed centrifuge. For that matter, no modern laboratory should be without such a centrifuge. While a heavy, high speed centrifuge is not necessary for routine urine analysis, it is necessary for blood chemistry work, research work, preparation of autogenous vaccines, malaria plasmodia concentration procedure, stool concentration for parasite eggs, and searches for tubercle bacilli in spinal fluid, etc. Therefore the installation of an expensive centrifuge for a possibly rare case demanding intraspinous treatment is not the only consideration.

The Swift-Ellis technique is as follows: One-half hour after intravenous arsphenamine, 50 cc. of blood is withdrawn from a vein into a sterile 50 cc. syringe, or the blood may be sucked into a partial vacuum in a large sterile centrifuge tube. The latter system is preferable as it helps obviate danger of contamination, and aids in preventing hemolysis by cutting out one more step in the handling of the blood.

This partial vacuum suction system is very simply made as follows: Through the openings of a two-holed rubber stopper which closely fits the centrifuge tube, pass two glass elbows. The ends of the glass elbows inside the centrifuge tube should extend no more than a centimeter beyond the cork. The exterior arm of one of the glass elbows should be about six centimeters in length and is connected by a short piece of rubber tubing to an adaptor which fits into the needle to be inserted into the vein. The exterior arm of the other elbow should be considerably longer and bent into a U-shaped depression in its middle to trap moisture. Another short piece of rubber tubing on the end of this latter leads to the mouth of the operator, who by sucking partially exhausts the centrifuge tube, when the system is connected to the needle in the patient's vein. The tourniquet is tied not too tightly so that the arterial pulse at the wrist is still distinctly felt; or the arm band of a blood-pressure outfit is inflated to just diastolic pressure. A nurse should hold the centrifuge tube while the doctor exerts suction. After filling the centrifuge tube, it is stoppered by a sterile cotton plug through which has been passed a large safety-pin to prevent the plug from falling inward during centrifugalization. The blood is first allowed to clot, then centrifuged for a half hour at high speed. The supernatant fluid is pipetted off by a sterile pipette into a second sterile centrifuge tube with a similar cotton plug, and centrifuged a second time for a half hour at high speed. Only a few red blood cells will be found now in the bottom of the centrifuge tube. Ten cc. of the serum is now pipetted into a third test tube already containing ten cc. of sterile distilled water. This mixture of serum and water is inactivated for one hour at 57 degrees to kill any possible organisms present. Lumbar puncture is now done, twenty cc. of fluid removed, and the mixture of arsenized serum and water allowed to flow into the spinal canal from a syringe through a short rubber tubing with an adaptor at one end to fit the end of the lumbar puncture needle. The injection of serum is made very slowly.

Where many intraspinous treatments are given in a week, a large amount of serum may be prepared at once. Such a stock of serum may be kept for two weeks for intraspinous injection of several patients.

McCook Hospital Organizes Staff. On February 21st the doctors of McCook, Nebraska, met for the purpose of organizing a hospital staff.

Rev. Charles B. Moulinier, S. J., president of the Catholic Hospital Association, was present and addressed the doctors on the subject of "Standardization." His remarks were received enthusiastically and there was shown a marked interest in the purposes of standardization as set forth by the Reverend Father Moulinier.

Formal organization of the staff was completed as follows: president, Dr. R. R. Reed; secretary, Dr. G. A. De May; executive committee, Dr. R. R. Reed, Dr. G. A. De

New Misericordia Staff. Staff officers for 1924 in Misericordia Hospital, New York City, are as follows: president, Dr. Alexander H. Schmitt; vice-president, Dr. Ernest Fahnestock; recording secretary, Dr. Joseph A. Devlin; corresponding secretary, Dr. Frederick-Emil Neef; treasurer, Dr. Francis Butler.

The executive committee is composed of Dr. Ernest Fahnestock, Dr. Dennis McAuliffe, Dr. Anthony H. Harrigan, and Dr. Harry Michaelis.

The appointments were made at the annual meeting of the staff Tuesday, February 5th.

May, Dr. W. E. Knox, Dr. J. M. Willis, Sister Mary Pius, Sister Mary Zita, Sister Odilla. The record committee includes Dr. E. F. Leininger, Dr. R. B. Kepner, Dr. Elizabeth Hohl. Dr. Z. L. Kay, Dr. E. M. Easterday, and Dr. L. B. Swaggart comprise the nursing committee.

Organization of the staff places the hospital on an efficient working basis, and the Sisters of St. Dominic, who are in charge, anticipate that as a result the work of St. Catherine's will become more and more helpful to the patient, which is the ultimate aim of the modern hospital.

ONE OF THE PRIVATE ROOMS FOR MATERNITY PATIENTS IN OUR LADY OF THE LAKE SANITARIUM.

Hospital Progress

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ADVANTAGES OF DISPENSARY TRAINING

Since standardization was inaugurated a decade ago, the impetus given to hospital progress has been felt in every department, not only within the hospital itself, but even without its walls in the follow-up system and social service.

This latter feature in large centers has branched out into distinct lines and formed a long desired specialty—care of the unfortunates—particularly by teaching them, when feasible, how to care for themselves.

Out-patient departments especially are open fields for social welfare work, a work which at present is so systematized as to solve the many complex problems constantly cropping out in such environment.

The nurse who has the advantage of training in a hospital maintaining an out-patient dispensary, or in one connected with a school of medicine, which necessarily has a free clinic, is fortunate indeed. She has an opportunity for a larger and more varied service, growing out of these formative facilities. Closer contact with humanity in the rough, as we may style it, or unadorned with all the appurtenances characteristic of a well appointed hospital; constant association with the lower stratum of society, will naturally tend to enlist the nurse's sympathy and broaden her vision of future endeavor.

Environment plays an important part in character building, and who can gainsay the opportunities of such a training camp as a free dispensary, for one who in her life's work, and because of it, needs strength of character as does the nurse?

Sympathetic she must be, but not sentimental; affable, yet adamantine in not yielding one jot or title of the principles she acquired and began to put into practice in her arduous labors among the poorer ones of Christ's flock in the free dispensary.

—*W. P. W.*

BOYS' WEEK

This particular seven-day episode has recently come to our notice in the succession of yearly segments devoted to Thrift, Apples, Wheat Flour, and various other worthy motives and products.

One of the purposes of all these "weeks" is to stimulate individual thinking and cultivate proportion. Much that is said "this week" about *boys* will be quite as well applied to the rest of mankind, including *girls*.

Some one may well ask why this discussion on boys and girls should appear in a hospital journal. The answer is found in the old saying, "The child is father to the man." Children of today are going to be our hospital executives, doctors, and nurses of a decade, more or less, hence. Therefore we are vitally interested in forecasting and in determining upon those who have the greatest potential strength and opportunity, because we must all agree that we are going to need the best.

Somehow the idea grows that this is a wonderful age; that the period which has given us such great mechanical ingenuity and such excellent instruments of physical and thought transport, has also given us better minds, judgment, yes, even consciences. In some manner it is thought that universal education, diligently prescribed, will make of all, dutiful servants, just masters, and wise leaders or teachers. This is a superb sophistry. The human mind has not advanced one iota since the days of King Tut. We give too much credit to the accomplishments of stock breeders, and listen all too attentively to those who deify sports and worship physical development. "Man lives neither by bread alone" nor by his capacity to produce the ingredients that go into it.

Environment, from which so much is expected, and education, for which so much effort is expended, when compared with the inexorableness of heredity, are as if "scores of millions of years were compared with a moment" (Jelliffe). This is a somber thought! Those who are not in the business of cataloging and placing the multiplicity of misfits abounding in the world, are likely to view this in a practical light. A child is born either with intelligence or without it; those who come without it never get it, regardless of how far their education may proceed. Environment may be likened to a powerful vise that grasps a dense rubber ball; the mass conforms in a measure to the pressure about it. Nevertheless, unless the structure of the rubber is changed by some process of rebirth, it bounds back again to something like its original form as soon as the force is released.

The essentially good are rarely made evil by association with vice; the essentially vicious are equally rarely held to virtuous lives by even the most saintly example and strictest conventions. With all that is said, therefore, about the beauty of example and the power of right thinking, we must admit that knowledge may be quite as well exploited by thugs as by teachers. Recently a questionnaire came to hand from one of our class A medical schools, asking whether a man who had been convicted of the crime of burglary and had spent about two years in a penal institution, should be allowed to matriculate. The matter was submitted to a number of people, and we may presume that the final answers received by the institution will show as varied opinions generally as the questioner received locally.

It was interesting, however, to note the readiness with which many advanced the statement that while

such an applicant might well be accepted for many callings or professions, there was something distinctive about the trust reposed in those given medical licensure —something so keenly judicial about the calling of a physician as to make it unwise to admit to it any man who had shown sufficiently conclusive evidence of moral warping to receive an obviously just court sentence of two years. It might be retorted that we have plenty of burglars within the profession presently: men who have all the mental qualifications to steal, but not the courage to carry out the act!

Feeling still rules the world more than reason; it is evident that that situation of mind, or that basis of conduct, which one chooses through feeling, he will not abandon, even though orderly processes of thought reveal it as clearly unreasonable. Obviously, then, if we have any voice in the matter of selecting those who are to be our standard bearers for the future, we should give these simple situations plenty of thought.

A heavy responsibility rests on those who choose matriculants for any of the courses of higher training, with particular weight on those conducting medical schools and training schools for nurses.—*E. L. T.*

THE MODEL OF HOSPITAL WORKERS

Charity as we know it today came into the world with Christ. The tender pity for the sick and afflicted which gave birth to the hospitals of the past, as to the hospitals of the present, is a Christian virtue, even where it is found still exercising an influence on those who have departed from Christianity. As in the pagan nations of old, so in the pagan countries of today, men care for their own wants and needs and for those who are dear to or dependent on them. The abandoned and the wretched may live or die as they can—Christian charity is unknown.

The model of charity workers of any kind, especially of those who care for the sick in hospitals, is, therefore, Christ. He had a special pity for the sick and for those who suffered from bodily afflictions. Time and again the gospels tell of Him that He healed the lepers who cried out to Him, cured the helpless sick who were brought out in large numbers and laid in His path that He might see and pity them, relieved all the suffering who cried for His compassion.

This willingness of Christ to heal the sick was so conspicuous that his apostles wondered when He seemed to refuse the petition of the Cananite woman, and asked Him to make haste and heal her daughter because she cried out after them. His charity was boundless. He healed not only the just, but sinners; He relieved not only those who had fallen ill without their fault, but also those whose sufferings were the result of their sins.

He healed not only bodies, but souls. When He had relieved the distresses of the flesh, He ministered to the spirit, bidding the man He had cured, go and sin no more. He pitied bodily afflictions with divine charity because He saw in them the image of far worse spiritual diseases. He loved all men, seeing in them the image of His Father in Heaven.

This is a perfect example for those who work in hospitals. This wide and general charity, considering not so much the individual as Him for whom the individual is helped and cherished and loved, ministering to the soul as well as the body, seeking to save the spirit as well as the life, and to heal the inner wounds which have resulted in outer afflictions, is the ideal spirit of the Catholic hospital. All the latest developments in hospital work and management, the most effective means for healing mind and body, the most excellent methods of true social service in the hospital—what are these things but the manifestation of the charity which seeks in all things the healing of the distressed children of God for the love of God?

Rightly understood and intended, they are but a carrying out of the spirit of Christ, the model of all who work to heal the sick.—*E. F. G.*

OUR CONFERENCES FOR 1924

In this number of Hospital Progress the first announcement is made of the conferences the Catholic Hospital Association will hold this coming summer.

At a meeting of the executive board held at Mercy Hospital, Chicago, March 2nd, dates for the conferences were approved and the general outline of a program was adopted.

There are some few new and rather striking features about the activities which will be held this summer at Spring Bank. For the first time in our history, there will be two retreats given for the accommodation of those communities which wish to avail themselves of this convenience. While it is true that most communities either have a rule or a custom that retreats must be made in some house of the community, there are other communities which either have no such rule or custom, or have within the jurisdiction of superiors the power to suspend such rule or custom.

Hence, according to present indications, there will be a sufficient number of Sisters who will come for the retreats to make it worth while, and to indicate that they appreciate the opportunity to make this retreat in so quiet, beautiful, healthful, and inspiring a place. A specially selected retreat master will be secured, and every effort will be made to help the Sisters to make a most fervent retreat. Those who make the first retreat will attend the first week of conference, while those who come to the second week of conference will make the second retreat, if they so choose.

Another point of interest in regard to the conferences of this coming summer is that a very definite effort is being made to secure the presence of as many superiors as possible—mothers general, mothers provincial, local superiors, and as far as it is possible, others who have to do with the management of different departments in the hospitals.

This strong effort is being made because of the program that has been laid out, and, secondly, because

a special effort is being devoted to making the exhibits more of an educational feature than they have ever before been at our conferences. As the individual hospitals have been informed by Bulletin No. 6, the "soul of the hospital" is to be the general topic of discussion at all the conferences. By the soul of the hospital is meant the mind, the heart, the conscience of the hospital, and it is planned that all the papers and discussions will be about some phase of hospital life calculated to deepen and broaden the mental grasp of what a hospital should be in all that makes for better system, better government, stronger heart, and keener conscience.

Every day it is becoming more evident to those who are thinking out the problems of hospital administration that a hospital is a serious and difficult business undertaking, besides being a scientific, religious, and social institution intended for the best possible care of the sick.

It is quite evident, therefore, that it is the superiors and managers of our hospitals and their departments who should engage in the study of all these problems that have to do with the soul or interior life and function of the hospital. Hence, it is to be earnestly urged upon all the Sister leaders in our Catholic hospitals to make every effort to be present at these conferences.

The number of exhibits will be more than double what they were last year, and very painstaking efforts will be made to bring about a most helpful and instructive cooperation between the exhibitors and the Sister delegates. We are striving to have every phase of hospital activity, in as far as this is possible, represented amongst the exhibits. By their large attendance and intelligent interest in this business side of hospital life, the Sisters will show how eager they are to make their institutions as economical and, at the same time, efficient, as up-to-date business methods have made it possible.

Education is the one word that expresses the underlying aim and effort which will characterize the conferences of this coming summer. Spring Bank seems happily adapted to bring about the most practical results from a gathering of people who are intelligent and earnest in striving to gain a deeper insight into the problems that confront them in the daily life of the hospital. All who live day and night on Spring Bank grounds, where daily association, leisurely thought and conversation, earnest attention and discussion, frequent inspection and appraisal of the exhibits make it not only possible but easy and pleasant for them, if they are zealous-minded hospital workers, to accumulate impressions, opinions, and judgments on every phase of hospital care of the sick, acquire these in so impressive a way, that lasting and helpful convictions are sure to be carried away by all.

The Sisters in the East, that is east of Chicago, are to come for the first week of retreat and conference, while the Sisters of the West, including Chicago, are requested to come to the second week of conference and retreat. Though this is an arbitrary arrangement in order to make sure that accommodations will be ample for all who wish to come, it has in it an element of psychological interest which we believe will play a part in lending zest to the conferences. The East is older in hospital activities than the West, but some think that there is more vigor and aggressiveness in the West. The East has traditions—the West is making them. The East has the advantage of denser population—the West is inspired by a boundless territory. The East has age, while the West has youth. How interesting then it will be to observe the reaction on the minds of those from the East and from the West of a program entirely taken up with the educational problems of all phases of hospital work.

The program of the first week will be repeated during the second week. The same papers will be read at both. The discussions, however, will be characterized by the eastern and western points of view. What a study this will be for all if it will be possible to convey to all, the similarities and contrasts of achievement, of ambition, and of vision which will be displayed.

—*C. B. M.*

WHERE HONOR LEADS

Of all the professions, that of medicine, by and large, has the poorest knowledge of its historical background. It is deplorable that the medical schools have not required of their graduates, a knowledge of the history of medicine. There is no excuse for this ignorance of the development of our profession. The nursing profession has recognized the value of this to a far greater degree than has the medical, and insists that its graduates have some knowledge of the history of nursing. Of course the history of nursing as a profession with prescribed standards is very modern, though in many periods at least of the world's history, nursing was perhaps just as proficient as medicine, since from the early centuries of the Christian era, beginning about the fourth, nursing orders of Sisters were wherever the Church was. Probably indeed the first nurse was Eve, because after our first parents were driven out of the Garden of Eden, undoubtedly the first time Adam stubbed his toe he appealed to Eve for sympathetic care and advice.

In our country, perhaps more than in any other, it seems imperative that the profession have a knowledge of the development of the science and the art of medicine. Under our system of government where any native-born male citizen may aspire to be president of the United States, the profession is open to all classes. This means, without any disrespect, that our profession is not made up of the same class, as a whole, as is the profession in Europe, for instance. There, caste has prevailed to a marked degree, even in the most democratic countries, and the profession comes largely, if not entirely, from a class that has traditions to maintain and family honor to uphold. Whereas in our country both the nursing and the medical professions

Annual Conferences and Retreats of the Catholic Hospital Association at Spring Bank

Six Weeks: June 21st to August 2nd, 1924.

According to the following schedule:

Sisters

First Retreat for Sisters—Evening of June 21st to Morning of June 29th.

First Week of Conferences—June 30th to July 5th, inclusive.

Second Week of Conferences—July 7th to July 12th, inclusive.

Second Retreat for Sisters—Evening of July 12th to Morning of July 20th.

Nurses

Conference of Candidates for International Catholic Guild of Nurses, as well as Non-Candidates—June 21st to June 28th.

Organization Meeting.

Retreat of Two and One-half Days.

Vacation Period of One or Two Weeks.

Doctors

Conference—July 21st to July 23rd, inclusive.

Retreat—July 24th to July 26th, inclusive.

Vacation Period of Week or Ten Days.

THE GENERAL PRELIMINARY PROGRAM

Subject: The Soul of the Hospital

I. Present-day Tendencies in the Hospital World.
- **A. General Business Management.**
- **B. Administration of Personnel.**
- **C. Staff Management and Betterment.**
- **D. Nursing Efficiency.**
- **E. Choice of Hospital Location.**

II. Education for Hospital Work.
- **A. Preliminary Requirements.**
- **B. Special Training.**
- **C. Spiritual and Religious Training of Sisters, Nurses, Helpers, Doctors, and Patients.**
- **D. Our Crusade for Vocations.**
- **E. Sodalities—Guilds—Service Society—for All Hospital Workers.**
- **F. Courses in Hospital Ethics.**

III. Reports of Committees, by Chairmen.

IV. Business Meetings—Election of Officers and Executive Board.

V. Discussions will follow each paper.

are open to any ambitious boy or girl, and for this reason the rank and file of both professions are necessarily made of more diverse characters.

This inevitably means that not all who succeed in getting a medical diploma or a certificate as graduate nurse, are either by educational background or heredity capable of living up to the highest ideals of what these professions should stand for. For this reason I believe that an organization like that of the Catholic Hospital Association should endeavor, both through its nursing members and the staffs in its hospitals, to set the very highest ideals for our institutions and for the practitioners therein. We must all freely admit that this ideal has not yet been nearly approached.

It is imperative that the Sisters in charge of our hospitals so choose their staff that only those qualified shall be admitted.

Again, not every doctor competent to treat certain classes of cases is competent to treat *all* kinds of cases—hence the need of consultations and *real* staff conferences.

The surveys made by the American College of Surgeons and the A. M. A. Hospital Committee have clearly demonstrated that much inferior work is being done, even in good hospitals. The work is "spotted" because proper supervision is not exercised by the administration in permitting operations by those not qualified to do them. And the same perhaps is equally true of many medical cases. The American College of Surgeons prescribes as a minimum that operations of a serious nature should be performed only by those who by education and training have qualified themselves as surgeons. They demand that a man desiring to do surgery and holding himself out as a surgeon, must, after his graduation and internship, serve as an assistant to a recognized surgeon for several years before undertaking serious operations on his own account. Of course not all the good surgeons are F. A. C. S., but the College minimum requirement should be the aim of the Catholic Hospital Association.

It is neither fair nor honest to the patient or to the qualified men on the staff, that men lacking these qualifications should be allowed to do major surgery without supervision. We feel sure, too, that the matter of records is often reduced to an absurdity inasmuch as the inspection of hospitals for standardization is often made on the character of the records, without the inspector's going back of the records to the man or men who make them and investigating why operations were done, why cases were thus diagnosed and treated. The records, no matter how well kept, do not always show this, and the character of the man and his ability should certainly be paramount to the completeness of the record.

Thus, honor leads us to supervise carefully the work in our hospitals. This burden necessarily falls in the first place on the Sister superior. If she is not a woman of intelligence, good hospital training, unbending character, when the right of the patient is concerned, and one who puts the welfare of the hospital clientele above monetary considerations, it is impossible to have a hospital where the patient may be assured of safety and the best treatment procurable through medical science. The Sister superior who has these commendable qualities will see that her staff is composed of dependable, scientific practitioners who keep themselves up to the minute in their profession by frequent clinical visits to other hospitals and by necessary postgraduate studies. In such an institution honor reigns.—*E. E.*

THE ORTHOPEDIC WARD AT SANTA ROSA INFIRMARY, SAN ANTONIO, TEXAS, MAY BECOME THE NUCLEUS OF A HOSPITAL FOR CRIPPLED CHILDREN.

Proposed Orthopedic Building for Santa Rosa Infirmary

One of the outstanding philanthropic movements in the history of San Antonio, Texas, was the organization two years ago of the Crippled Children's Association, and the establishment of a ward at Santa Rosa Infirmary for the care of crippled children financially unable to receive proper treatment. Many of San Antonio's leading physicians and surgeons have supplemented this charitable work made possible through the efforts and donations of interested Texans, by giving their services without compensation.

With the consent of the Sister Superior of Santa Rosa Infirmary, the Crippled Children's Association was chartered by the Secretary of State some months after its inception.

The purpose of the association, as set forth in the constitution, is the reception, examination, treatment, and education of crippled children regardless of race, color, or religion. It proposes to care for the mental, moral, and physical welfare of such children during the time of treatment. This work is not confined to the crippled children of San Antonio alone; it is available to any child of the state who needs orthopedic treatment and lacks funds to defray the expenses of his stay in a hospital. The by-laws provide for two classes of members: active, never in excess of thirty; and patrons, that is, all who are interested in the association.

Treatment is managed on a strictly charitable basis, funds being supplied by donations from interested people of the city. These gifts, together with the proceeds from concerts and other entertainments, furnished a ward and provided a surplus for the purchase of braces and crutches.

In connection with the ward is a clinic where children may be examined every Saturday morning by specialists in orthopedic cases. Children waiting to enter the ward, as well as those discharged after they are able to walk with the use of crutches and braces, avail themselves of this opportunity to receive treatment.

In November, 1922, a Tag Day was set aside for the purpose of replenishing the depleted treasury. The appeal met with the generous response of five thousand dollars and the members of the association were accordingly encouraged to make Tag Day an annual event.

Another progressive thought was advanced at a meeting held in June, 1923, when the organizers expressed the hope that a hospital for crippled children might be built in San Antonio within the next few years. With this in view, the following October 30th was set aside as Tag Day.

The last days of Ooctober were active days of preparation. Committees were formed, letters were sent broadcast to prominent citizens and to pastors of all de-

(LEFT) CONDITION OF BOY'S FOOT ON ENTRANCE TO SANTA ROSA INFIRMARY.

(RIGHT) APPEARANCE WHEN PATIENT WAS DISMISSED THREE MONTHS LATER.

THE WARD IS BRIGHT AND CHEERFUL.

nominations, asking them to interest their congregations in the great work. Minute plans were likewise mapped out for a parade of the crippled children as a personal appeal to the charity of the public.

At an early hour on October 30th the busy workers assembled at their allotted places. As soon as the streets of the city were astir with men and women hurrying to their posts of duty, the little tag with its human appeal, made its appearance. Young girls, busy housewives, leaders of society, nurses in spotless uniforms, volunteered their services for the day in behalf of the Crippled Children's Association, and pinned on thousands of breasts the tag symbolizing a contribution. Despite the inclemency of the weather the committees worked assiduously tagging the willing throng, which gradually increased, until the church bells pealed forth announcing the main feature of the day—the crippled children's parade and the various feats performed at the Majestic Theater.

The street announcer heralded the parade, followed by eight nurses of the Santa Rosa Infirmary carrying two large American flags into which the public had been urged to throw liberal contributions. To the strains of martial music, automobiles, floats, and ambulances proceeded onward carrying their precious burdens through the business sections of the city. The afflicted little ones, with bent and twisted limbs, seemed to forget their ills in their enthusiasm over the ride, and joyously left the ward waving good-byes and farewells to the spectators. As the parade moved along, the people responded generously to the mute appeal of the helpless children. The work progressed until late that night when final efforts were made in the theaters of the city.

The Tag Day was a great triumph, and San Antonio had again demonstrated that its heart was as great as its history.

This success means that many of the poor little children with deformities that handicap them now, will have the chance to grow up fine and strong like the rest of their friends. It means that many of the little twisted forms, the tiny misfits of civilization who suffer in dismal homes today, will have an opportunity for medical attention and loving care. It means that the present small but cheerful

A LIGHT TREATMENT.

INTERN GIVING A TREATMENT.

LITTLE GIRL, TEN YEARS OLD, BEFORE TREATMENT.

THE SAME LITTLE GIRL ON THE MORNING SHE LEFT THE HOSPITAL AFTER EIGHT MONTHS OF CARE.

PATIENT, AGED 20, ON THE DAY SHE ENTERED SANTA ROSA'S ORTHOPEDIC DEPARTMENT.

SAME PATIENT AFTER TWELVE MONTHS' TREATMENT.

ward will develop and grow until one day it is replaced by a Children's Orthopedic Hospital which will be the pride and joy of San Antonio's generous-hearted citizens.

TUBERCULOSIS OF THE BONES AND JOINTS

Edward A. Cayo, M.D., San Antonio, Texas

Our present day knowledge of tuberculosis of the bones and joints assures us that in most cases of uncomplicated tuberculosis of these tissues the disease can be arrested; that where the disease can be arrested the majority of cases can be cured; and that most of these healed cases can be cured without deformity or disability. In other words, early diagnosis and guarded treatment.

In tuberculosis of the bones and joints we are asked specifically about the diagnosis, the treatment, and the prognosis; a responsibility rather worthy of a foundation.

In the work of diagnosis, then, we investigate the history, the clinical picture, and the laboratory findings, and finally confirm the whole work by means of exclusion. With a balanced experience sufficiently seasoned for an appreciation and interpretation of these factors of diagnosis, tuberculosis of the bones and joints will only rarely escape being recognized on first investigation. In some cases we may be prompted to state the diagnosis before exhausting our means of investigation. But a worthy diagnosis is one fortified by a complete analysis of the factors relating to the case. Although we all know about these factors of diagnosis, we do not always apply the knowledge with the result that the patient receives the necessary special treatment during the early stages of the disease.

When it is determined that a joint is affected with tuberculosis, treatment becomes the subject for consideration. In the handling of this type of tuberculosis many factors come up for consideration, and with their proper application the prognosis in uncomplicated tuberculosis of the bones and joints is very good.

Present day treatment of tuberculosis of the bones and joints is broad enough to beneficially apply the following measures:

(1) Balanced diet.
(2) General body hygiene.
(3) Rest for the diseased tissues.
(4) Comfortable, hygienic living quarters.
(5) Actinotherapy, preferably from the mercury-quartz lamps.
(6) Daily massage, and daily active exercise of the whole body, except of those parts involved in the disease.
(7) Systematic entertainment.

The patient's diet can be so regulated that there will not be an excess accumulation of fat. A relative amount of fatty tissue, as reserve food, etc., is advisable. An excess of fatty tissue, however, interferes with muscle physiology and therefore is a burden, especially to the circulatory system.

General body hygiene. Measures which shock, or tend to shock. the patient, such as a cold bath or a hot bath, etc., will lower the patient's resistance instead of doing good. We give the necessary bath, but we make that bath a luxury rather than a depressing duty. It is evident that there is a limit to the shock-absorbing power of the central nervous system, and that impulses from the periphery through the center to the vegetative nervous system and its associated organs, can be controlled more or less as we control the food entering the blood stream, by allowing only certain substances to go into the alimentary canal.

Rest for the diseased tissues. This means that we do not irritate the diseased or regenerating tissues, or subject them to mechanical pressure above that of the peripheral circulation. Therefore we control muscle action and body weight.

Comfortable hygienic living quarters. General comfort for the patient is the central structure in our treatment. Patients do best when they are comfortable.

Actinotherapy. This treatment is most beneficial, and can be properly controlled when applied by means of mercury-quartz lamps. The rays are usually applied from the air-cooled lamp to the whole body, chiefly for their effect on the circulation. With the water cooled lamp the rays are applied for their local effect, bactericidal and stimulative.

Daily massage. This represents passive exercise, and thus effectively assists the circulation.

Active muscle exercise. Body resistance, both external and internal, is not at its best unless the muscle tissue is daily functioning within its normal physiology. Consequently, every muscle which does not interfere with the diseased tissue is kept energetically active.

Systematic entertainment. To keep the patient from depressing worries it is best to provide a program such as will agreeably account for the time during waking hours.

To manage tuberculosis of the bones and joints as here outlined it is best to have the patient in a hospital where necessary equipment and assistance are available.

Blood and Bile Pigment Changes in a Case of Bothriocephalic Anemia

A Case History

M. G. Gillespie, M.D., St. Mary's Hospital Staff, Duluth, Minnesota.

It was in 1916[1] that Schneider first published a simple method for securing duodenal contents and the spectroscopic method of measuring the urobilin and urobilinogen content of bile. Since then various investigators, chiefly Schneider, Giffen, Sanford, and Szlapka, have applied the technic to the study of bile in many pathologic conditions, notably in pernicious anemia, hemolytic icterus, secondary anemia, syphilis, carcinoma, and leukemia.

The somewhat similar picture of dibothriocephalic anemia and pernicious anemia has long been noted. The severe degree of anemia which may occur, the high hemoglobin index, icterus, leucopenia, and achlorhydria are common to both and may present a confusing picture.

It was thought that studies of the bile pigment values in a case of dibothriocephalus latus, which came under my observation, would be interesting and perhaps of scientific value.

The method and technic used is that described by Giffen, Sanford, and Szlapka[2].

I submit herewith the case history, the results obtained, and the conclusions arrived at.

Case History. Case Number 83659.

O. C., a laborer, age 33 years, first came under by observation in July, 1923, while he was a patient at the Public Health Venereal Clinic maintained at St. Mary's Hospital. While under treatment he complained bitterly that after each intravenous injection he was literally "knocked out" for a few days. I advised him to enter the hospital and on August 24th, 1923, he was admitted.

Complaint:

Weakness, tired feeling, loss of strength and weight, puffiness of hands, feet, and face.

Family History:

Father died of "old age." Mother, two brothers, and one sister, well, living in Finland. Nine brothers and sisters died of unknown causes at various ages.

Marital History:

Single.

Past History:

Born in Finland. Has lived in this country for eleven years. "Flu" in 1908. Gonorrhoea and two penile sores at the same time three years ago. Always in good general health until the Fall of 1922. A blood test was taken in Feb., 1923, and he was told he had syphilis. Since March, 1923, he has had eight arm and four hip treatments. This past Spring he had a small sore on the tongue which, however, persisted for only a short time.

Present Illness:

Patient was well until the latter part of 1922. The onset of his illness was insidious and not clearly defined. During the fall and winter months he became tired on the least exertion, felt weak, and finally was unable to work steadily. In March, 1923, he had a right-sided serotal swelling which lasted about two weeks. Since March this weakness has progressed. His appetite has been poor. On exertion he complained of pain in the chest. Since the first of the year he has lost fifteen pounds in weight.

Physical Examination:

Examination revealed a young man of Finnish descent. Body poorly nourished and musculature flabby. He looked tired and each movement suggested a loss of vigor and strength. Temperature was 96 degrees. Pulse, 100. Complexion was sallow. Sclerae icteric. The face, especially below the eyes, and the dorsum of the hands and feet, were puffy.

The pupils were equal and reacted to light and accommodation. The teeth showed lack of care. There was moderate caries present with pyorrhoea and gingivitis. Tonsils were small. The buccal mucosa was pale. Small discrete glands were palpable in the anterior and posterior cervical, the axillary and inguinal regions. Examination of the lungs revealed no definite pathological findings. Examination of the heart was negative, except for a soft systolic murmur heard over the base to the left of the sternum. Palpation of the abdomen was negative. The right testicle was atrophic.

Neurological examination revealed normal coordination, stereognostic and deep position sense. Pain, touch, and temperature senses were undisturbed. There was no loss of reflexes. Biceps, triceps, and knee-jerks were equal. Babinski and cloni were absent.

Blood pressure, August 27th, 1923, 140/70.

Rectal Examination:

There were no external hemorrhoids visible. The rectum was empty. No obstruction or induration was met with by the palpating finger. Prostate was normal in size and consistency.

Laboratory:

Urine: Sp. gr. 1010. No albumin or sugar. Microscopic examination negative.

Blood count August 25th, 1923.

Hgb. 35 per cent (Sahli). R. B. C. 1,450,000. W. B. C. 3,900. Index 1.2.

Differential: Polymorphonuclears 65 per cent. Lymphocytes 35 per cent.

Red cells showed marked anisocytosis and poikilocytosis.

Fragility test September 2nd, 1923. "Giffen, Sanford" 0.42 per cent—0.32 per cent.

Ewald test meal August 28th, 1923.

Amount 10 c.c. Free Hcl. 0. Total acids 51.0. Some mucus. No lactic acid or blood.

Feces August 29th, 1923.

Ova of dibothriocephalus latus found. No occult blood. blood.

Wassermann positive.

Subsequent course: As soon as the ova were discovered, treatment was instituted and a specimen of bothriocephalus latus, about eight meters in length, was recovered. There was no gross evidence of disintegration of the worm. The day following the expulsion, the bile pigment values were determined with the following results: urobilin 1200, urobilinogen 1400. Total 2600. Bilirubin four plus.

Fourteen days later the second determination was made and the following values obtained: urobilin 900, urobilinogen 600. Total 1500. Bilirubin four plus.

The day following this second determination the blood count was: Hgb. 40 per cent (Sahli); R. B. C. 1,800,000; index 1.1; W. B. C. 5,500. Differential neutrophiles 63 per cent, lymphocytes 37 per cent. Anisocytosis, poikilocytosis, and polychromatophilia were present.

Twenty-six days after his admission to the hospital the patient was discharged in much better physical condition. The pulse which upon entrance was around 100,

[1]The Splenic Pathology of Pernicious Anemia and Allied Conditions. A Duodenal Method of Estimating Hemolysis. Arch. Int. Med. 17:32—Jan., 1916.

[2]The Estimation of Urobilin and Urobilinogen in the Duodenal Contents. Amer. J. M. Sc. 155:562-563—April, 1918.

now ranged between 70 and 80. The temperature which upon entrance was subnormal, upon discharge had risen to the normal level. The complexion had improved. The puffiness of the face and limbs had disappeared in large measure. These changes were coincident with an increase in strength and a feeling of well-being.

Thirty-four days after his admission to the hospital the blood count had risen to: Hgb. 55 per cent (Sahli); R. B. C. 2,920,000; W. B. C. 6,600. Index, 0.94.

Discussion:

The patient had resided in this country eleven years. He had come from Finland. Whether he was infected in Finland and the worm had remained dormant, or whether he had acquired the infection in this country, is problematical.

He had remained well until approximately eight months ago, when the toxicity of the worm began to manifest itself. The parasite showed no gross evidence of disintegration, in contradistinction to the investigations of Faust and Tallquist, who have brought forward the hypothesis that toxic manifestations are due to the absorption of decomposition products of the disintegrating segments.

The bile pigment determinations showed an abnormal amount of urobilin, and the abnormal presence of urobilinogen. Under normal conditions the amount of urobilin does not exceed 1000 units, and there is an absence of urobilinogen pigment.

In Schneider's[3] series of determinations in pernicious anemia patients, the average total of bile pigments was 3.330 units. In this case the total values were 2600 and 1500 units, the latter determination made after the anemia had begun to improve.

The total amounts of pigment values obtained in this case are comparable to the total amounts in the average case of pernicious anemia, proving that this type of anemia, as in pernicious anemia, is a true hemolytic anemia.

The positive Wassermann together with the suggestion. In the absence of clinical manifestations of syphilis, and considering the findings and subsequent course, I believe we can rule out lues as a possible origin of the anemia. However, the positive Wassermann may have been incidental, as sometimes occurs in severe anemia.

There arises also the possible relationship of the arsenical therapy to the anemia. In the light of the findings and subsequent cause, it is doubtful that antiluetic treatment was a source in the production of the anemia.

Summary:

A case of dibothriocephalus latus is reported. A positive Wassermann without any clinical manifestations of syphilis was present. There was a severe anemia present with a high hemoglobin index. Ewald test meal showed an absence of free hydrochloric acid. The ova of the dibothriocephalus latus were found in the stool. After expulsion of the parasite the anemia improved. The worm showed no gross evidence of disintegration or decomposition. Urobilin was in excess of the normal, and urobilinogen was abnormally present. The total urobilin and urobilinogen values of the duodenal contents were comparable to those values obtained in the average pernicious anemia patient.

Acknowledgment is due Dr. T. R. Martin for his helpful suggestions and instruction in the preparation of this case history.

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[3]A Study of the Bile Pigments in Pernicious Anemia. J. A. M. A. June 26, 1920. Vol. 74, pp. 1759-1763.

Bilateral Nephrolithiasis: Report of a Case

Edward F. Kilbane, M.D., New York.

From the Genito-Urinary Service, Misericordia Hospital, New York:

The patient, Mr. W. F. C., age 40, a construction engineer, was referred to the writer by Dr. William E. Young, with a history of attacks of renal colic extending over the preceding nine years. The first attack came on while the patient was in a telephone booth putting through a long distance call. The onset was so sudden and the pain in the left flank so severe that he was unable to continue the telephone conversation and had to be assisted from the booth to a bed at a hotel. The attack lasted several hours during which he vomited several times. The pain ceased as suddenly as it began and a few hours afterward a small calculus was voided.

In the nine years following, attacks recurred many times at irregular intervals and with varying severity, some lasting for hours with excruciating pain, much nausea and vomiting; other attacks with only a slight amount of pain, lasted less than one hour and were accompanied by a little vomiting or only nausea. After each attack a small calculus was voided. During the past year he had also had attacks of the same character with the pain on the right side. Blood had never been noticed in the urine, nor had there been dysuria, increased frequency or urgency of urination, or other symptoms of disturbed bladder function.

His general health had been failing for some time and he had lost thirty pounds in weight but had been able to continue at his work except while the colic was present. Otherwise, with the exception of measles, chicken-pox, and whooping cough in childhood, and the amputation of a finger following an injury, he had always been well. And it might be well to note at this time that he had never had tonsilitis. The patient had no knowledge of calculus disease in his family. His father died of an unknown cause at the age of 70; his mother of apoplexy at 60; and his two sisters were alive and well.

Physical examination: Patient is poorly nourished and looks drawn and tired. Weight, 110 pounds. There tive history of infection, suggests a coincident luetic inheart and lungs are normal, there are no abdominal masses or muscular rigidity and no abnormalities of the skin, bones, joints, or of the glandular or musculo-neural systems. Urinalysis: color turbid, reaction acid, specific gravity 1012, heavy trace albumen, no sugar. Microscopical examination: much pus, many hyaline and granular casts. During a test period of one hour the patient secreted 125 c.c. of urine, or the equivalent of 3000 c.c. in 24 hours. Blood chemistry: urea 37.5, uric acid 4.1, creatinin 1.7, sugar 146, chlorides 624; each substance being expressed as milligrams per 100 c.c. of blood plasma. It will be noted that all the blood figures are high. Quantitative urinalysis of a specimen of the urine secreted during the hour test period shows urea 0.62 per cent, uric acid 0.018 per cent, creatinin 0.031 per cent, sugar 0.026 per cent, chlorides 0.61 per cent. As it was noted that all of the blood figures were high, here it will be noted that all of the figures for the urine are low. In view of these findings an examination of the eye grounds was made which disclosed no pathology significant of disturbed renal function.

The carbon dioxide absorption capacity of the blood plasma, 65 per cent. Acidity of the urine in terms of N/10

acid per litre, 90. Ammonia in urine in terms of N/10 acid per litre, 100. Daily output of ammonia at this rate, 0.51 grams. Acidosis coefficient as shown by the urine 12.6. No acetone in the blood plasma nor in the urine and no diacetic acid in the urine.

Roentgenograms show shadows in the region of each kidney. There appear to be multiple shadows on either side but it is impossible to determine the number as the shadows are of different densities and apparently merge into each other.

Cystoscopic examination, Feb. 28th, 1923: bladder tolerance and bladder capacity are normal. The bladder mucosa is somewhat dull in color. There are no ulcerations present. The ureteral orifices are normal in appearance and position and both sides are observed secreting urine into the bladder at regular and frequent intervals, the discharge from the right ureter being clear, that from the left ureter purulent in character. Phenolsulphonephthalein injected intravenously appears in the urine from each kidney within four minutes. Catheters pass up either ureter to the pelves, no obstructions being noted. The flow of urine begins through either catheter immediately, normally intermittent in character, and rapid in rate. No residual urine in either pelvis. The urine from the left side is turbid in gross appearance, that from the right kidney is clear, of higher specific gravity, and contains more of the dye.

Pyelograms of the right pelvis show some dilatation of the pelvis but good terminal markings of the calyces. On the left side there is blunting of the terminal calyces and dilatation of the pelvis. The urine from either kidney contains a heavy trace of albumen, hyaline and granular casts, and many pus cells. Left kidney urine on culture contains 90 colonies of B. coli communis per c.c. of urine, that from the right remains sterile, no growth having occurred at the end of 48 hours.

The patient stated that after a previous examination at another clinic, he was informed that the left kidney had ceased to function. It is possible that at the time of this preceding examination, the calculus afterwards removed from the left ureter was so situated as to cause complete blocking, or there was a temporary cessation of the function of the left kidney.

Removal of the calculi seemed imperative in view of the severity and frequency of the attacks of colic, the loss in weight, and failing health, and especially because of the lowered renal functions and high plasma figures, denoting such a marked disturbance of the kidney excretory function. Because the left kidney was believed to be the more involved, it was operated on first.

Operation March 3rd, 1923. Anaesthetic, G and E. With the patient on his right side the incision was made from above downwards and forward, from a point above and just within the tip of the last rib, downward and forward to a point one inch in front of the anterior superior iliac spine, through skin, fascia, and muscles, exposing the perirenal tissues. The kidney capsule was opened, the kidney freed by finger dissection, and the kidney delivered. The peripelvic tissue was then carefully dissected. On exposing the pelvis, it was found to be large and distended by fluid under tension. The pelvis was incised, liberating about ten c.c. of pus. Two small calculi were found in the pelvis and easily removed. One, globular in shape with a smooth surface, was .3 cm. in diameter. The second, shaped like a kernel of corn, also smooth of surface, was 1.5 cm. long and .5 cm. in diameter at one end, tapering to a point at the other. A probe was passed a distance of 5 cm. down the ureter, where an obstruction was encountered preventing its further passage. Feeling along the ureter I was able to feel another calculus in the ureter at the point where the probe was obstructed but was not able to milk it up the ureter into the pelvis for delivery through the pelvic incision. The ureter was incised immediately over the calculus and the latter removed. This calculus, irregularly square in shape and with a very rough surface, was 1 cm. x 1 cm. x 5 cm. in size, and had been impacted in the ureter by diminution in the size of the ureter immediately above and below its location. The strictures evidently were the result of inflammatory reaction in the duct. Fine catgut sutures were used to close the incision in the ureter and pelvis, with an additional row to whip a layer of peripelvic tissue over the pelvic opening. Two wrapped gauze drains were inserted, one to the incision in the ureter and the other to the pelvis, and the wound was then approximated in the usual manner.

When the kidney was delivered into the wound it was seen that the surface was irregular and mottled. The notation was made at the time that the kidney would probably be removed if the opposite kidney were normal but in view of the cystoscopic and x-ray findings such a course was impossible.

There was practically no leakage from the wound and the patient made an uneventful recovery.

Second operation, right nephrolithotomy, April 19th, 1923; G and E. Same approach as in the first operation. During the exposure of the right kidney the lower portion of the right pleura was accidently opened. The rent was immediately closed with catgut sutures. The kidney was exposed and freed by blunt finger dissection plus a few incisions of adherent fascia between ligatures. A large calculus was felt in the kidney, too large to remove through the pelvis. An incision was then made through the kidney to the calculus, and the latter removed. Hemorrhage was moderate throughout this manipulation, bleeding being readily controlled by the digital pressure of an assistant on the vascular pedicle. The kidney was then sutured with chronic gut mattress sutures and replaced. A wrapped gauze drain was placed down to the incision in the kidney and the wound closed in the usual manner.

The calculus was 4 cm. long and shaped roughly like an aeroplane propeller with expanded ends. One blade was smooth, the other rough and nodular. Recovery was uneventful.

Following his discharge from the hospital, the patient rapidly regained weight and strength, and was soon able to continue his rather trying and exacting work. At intervals he returned for examination and treatment, the latter consisting of lavage of the kidney pelves with one per cent solution of silver nitrate. While his work has necessitated frequent and long absences from home, there has been a steady and continuous improvement in the urine as evidenced by the decreasing number of pus cells. The post-operative treatment has included the administration of urotropin and acid sodium phosphate, the ingestion of an abundance of water, moderation in diet, and the obvious hygienic precautions regarding exposure to wet and cold.

In the study of this case several interesting points are presented. The length of time the condition had been present, some nine years in all, would lead one to expect a more extensive destruction of renal substance than had occurred. The gastro-intestinal symptoms had been prominent, which is not unusual in calculus disease, and when the pain is right sided and there are no symptoms calling attention to the urinary tract this might easily lead to a mistaken diagnosis of acute appendicitis. Hematuria is usually present but its absence is not uncommon. Conversely, hematuria may be present repeatedly before the onset of any pain, although the latter is almost always present at some time in the course of the condition. In the writer's experience only one patient passed a calculus from the kidney pelvis, down the ureter into the bladder and then voided it without pain. In this instance the kidney on the affected side had two ureters from a single pelvis. The pain of renal colic is due to the distention of the ureter and pelvis with urine held back by the calculus. The size of the calculus seems to have little or no bearing on the severity of the pain, as the most excruciating pain may be present with very small calculi. The complete occlusion of the ureter is then due to the griping of the calculus by the spasmodic ureter. Per contra a calculus may descend a considerable distance down a ureter without causing symptoms. By both x-ray and cystoscopic examination we have repeatedly been able

to demonstrate an excursion of as much as 15 cm. in a period during which the patient was entirely free from symptoms.

If we consider that the bleeding is due to trauma incident to the movement of the calculus in the urinary tract, and that pain is due to back pressure from an arrested calculus, we can more readily understand many of the variations in the symptom complex of calculus disease.

The wide discrepancies in the findings at different examinations of the left kidney should make one extremely conservative in expressing an opinion as to the condition of a kidney from knowledge gained at one examination. At the first cystoscopic examination of this patient (made by a competent observer) there was an entire absence of flow from the left side, which led to the expressed belief that the kidney had ceased to function. Evidently at this time the calculus in the upper ureter was so situated as to prevent the passage of the catheter beyond it, or the escape of any urine down the ureter from the pelvis. At the operation the same condition was again present, with blocking of the ureter and distention of the pelvis with a purulent urine. At intermediate examinations an entirely different aspect was presented. A free flow of urine was obtained and a rapid elimination of phthalein occurred. Following the removal of the calculi there has been an entire absence of subjective symptoms with almost complete disappearance of microscopic pus and a return of kidney function close to normal, coincident with the general recovery of health.

The results emphasize the value of painstaking and, if necessary, repeated, pre-operative examinations and study.

The determination of which kidney to approach first was based on the generally accepted surgical practice of operating first on the kidney showing the more extensive involvement.

The discovery of an impacted calculus in the ureter 5 cm. below the pelvo-ureteral junction emphasizes the need of careful examination at the time of operation, even after sufficient calculi are found to explain all the roentgenological shadows.

So essential is careful examination to prevent undiscovered calculi from being left in the calyces or pelvis during operation, it is the writer's opinion that a fluoroscopic examination should be made of the exposed kidney before the conclusion of a nephrolithotomy or pelvilithotomy.

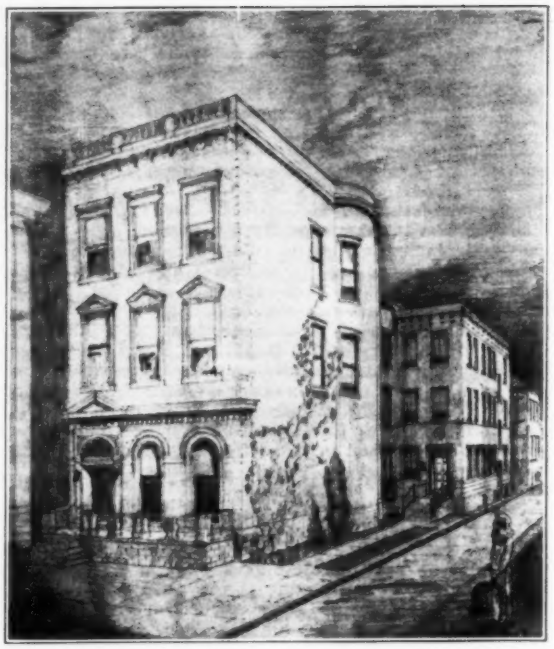
ESTABLISH GROUP PRACTICE CLINIC

Dr. Joseph L. De Courcy is constructing in Cincinnati, a group practice clinic with hospital facilities for the establishment of group practice. For a number of years Doctor De Courcy, who is a member of the staffs of the Good Samaritan and the Seton Hospitals, has been an advocate of group practice in medicine and surgery, and as a result he and his associates have introduced this principle in the treatment of patients.

A three-story office building located at 210 West Ninth St., Cincinnati, has been acquired, and an addition under construction will give the clinic building a capacity of 43 rooms. Patients admitted to the clinic will be given treatment as in the most modern hospitals.

A number of examination rooms will be located on the first floor. On the second floor will be offices for physicians in charge of the various services. Rooms will be provided where out-of-town patients can remain during examination, under the supervision of the staff and a corps of graduate nurses. Should a major operation be necessary, the patient may choose the hospital of his preference.

Among the services that will be provided are eye, ear, nose and throat, internal medicine, surgery, and x-ray. A special feature of the clinic will be the goiter service, which will occupy approximately an entire section for treatment and surgical work. An open forum for the public will be established for the dissemination of information on the treatment and prevention of goiter.



DE COURCY CLINIC, CINCINNATI.

On the third floor there will be a medical library and auditorium where discussions on medical and surgical subjects will be held.

"Group practice," according to Doctor De Courcy, "whether it be in the hospital or the clinic, is merely a group of physicians or practitioners who work in cooperation, doing at all times what they are expected to do, whether it be in a diagnostic or a therapeutic capacity.

"Although group practice within the hospital is a great improvement over the old method of consultation," says Doctor De Courcy, "a much better method, both for the physician and the patient, is coming into its own. I speak now of specialists grouping themselves together in so-called groups or clinics, thereby making their complete diagnosis at the office, and later if indicated, sending their patients to the hospital with the diagnosis made. This has proven an advantage to the patient, both scientifically and financially; scientifically, because a better examination can be made in a shorter time, due to the fact that different physicians are at their offices at the same time and can work in harmony, whereas in hospitals it is difficult for all to examine the patient conjointly; financially, because the patient is saved the expense of lying in the hospital four or five days awaiting the examinations of different men."

The new clinic will be opened for occupancy April 1st, when a number of notable physicians and surgeons will take part in the dedicatory exercises.

Interns Guests at Dinner. A dinner was given on February 12th, at St. Mary's Hospital, Grand Rapids, Mich., in honor of the physicians who have served the hospital as interns. Dr. S. L. O'Brien acted as toastmaster. The interns present at the dinner were Dr. O'Brien, Dr. J. J. Gainey, Dr. W. L. Dixon, Dr. John Whalen, Dr. O. A. Gillett, Dr. Frank Doran and Dr. Raymond Mendiola. Following the dinner, a radio concert was enjoyed.

Hospital Staff Elected. St. Mary's Hospital, at Long Beach, Calif., elected a staff on January 28th. The following officers were elected: president, Dr. T. O. Boyd; vice-president, Dr. G. A. Charlton; secretary, Dr. W. A. Dashiell. This is the first permanent staff to be appointed since the taking over of the hospital by the Sisters.

Sodalities for Graduate & Pupil Nurses

Establishing a Sodality

Rev. E. F. Garesché, S. J.

Practically, the process of establishing a sodality is very simple. Write to the nearest Jesuit Provincial, or, for the middle West, to the Sodality Editor of "The Queen's Work," and ask him to send blanks and instructions for affiliation. He will then forward these and the blank should be filled in with great care according to instructions, and signed by the person applying for affiliation, usually the chaplain of the hospital. On the blank containing space for the class of persons should be written, "nurses." Next comes another space for the title of the Blessed Virgin, and in this is written the feast or title of the Holy Mother, under which she is chosen as the chief patroness of the sodality. A favorite title is the Immaculate Conception. Our Lady, Help of the Sick, Consoler of the Afflicted, or a similar title would also be appropriate for a hospital sodality. Then follows a space for the name of the secondary patron, a saint chosen as a model for the sodalists, and for whom they are to have special devotion. St. John of God and St. Camillus of Lellis were nurses. St. Luke was a physician according to tradition. So were Sts. Cosmas and Damian. Sometimes local devotion will determine the choice of another patron.

The next thing to be determined, after filling in on the blank the name of the hospital, locality, etc., is the name of the director, who must be a priest. The chaplain is usually designated and it should be noted that his essential duties are few. He must receive the candidates or delegate some one else to do so but this can be done informally. All that is required is that the director be requested by the sodalist to admit her, and that he give some sign of his assent. Solemn and public receptions once or several times a year are much to be recommended but are not necessary.

Besides the director we strongly advise the appointment in every hospital of a sub-director, a Sister who will take care of all the details which the director himself cannot attend to. She can seek guidance of the director and find out from him how much he will be able to do, but the sodality should not depend too much on any individual and should be ready and able to conduct its meetings and carry on its activities even though the director is unavoidably prevented from giving it aid.

If the blank is filled out to read "chaplain of the hospital and his successors," then the bishop in signing the blank appoints the successors also as directors and they become authorized to receive members by the fact of their appointment as chaplain or pastor. Otherwise it would seem that a new appointment should be made by the bishop each time the former director departs. As this is inconvenient it is advisable to have some such provision for a successor.

The blanks contain also a request that the rules of 1910 be approved for the sodality. If any changes are asked for in the rules, or if any other rules are wanted, they should be included with the petition. The rules of 1910 are the edition of the "Common Rules for Sodalities Affiliated to the Prima Primaria" or Head Sodality of the Roman College revised in that year, and give the spirit and ideals which affiliated sodalities should have. Hence no changes are ordinarily needed. These rules do not bind, of course, under pain of sin but they should be studied and observed as far as circumstances will allow.

This blank then, duly filled out and signed, should be sent to the bishop with a request that he affix his own signature thereto. When he returns it, the "placet" as it is called, should be sent to the provincial from whom it came, and he will then apply for permission from Rome to issue a diploma. When this diploma is granted, the affiliated sodality begins to enjoy the privileges and indulgences of the head sodality of Rome. It sometimes takes several months for the letter to reach Rome and for the reply to be received. In the meantime the sodality may be organized and may begin its work.

The erection of the sodality, that is the calling of the sodality into being, is thus effected by the authority of the bishop when he gives his consent by signing the "placet." After it has been thus brought into being, the sodality is affiliated with the Head Sodality of the Roman College by the authority of the General of the Society of Jesus. Both these proceedings are essential to the gaining of indulgences. Only a sodality which has been duly erected or established can be affiliated, and only a sodality which has been duly affiliated can gain the indulgences.

In former times permission seems to have been given to certain other centers, as for example to the Sisters of Charity at Rue de Bac in Paris, to communicate the indulgences and privileges of the Head Sodality of the Roman College. But we have been informed from Rome that some time ago this privilege and permission were withdrawn and the Holy Father rules that any sodality which wishes to receive these special indulgences must be individually affiliated with the Prima Primaria, or Head Sodality of the Roman College. Hence this is now required for all sodalities.

The diploma which is sent to each affiliated sodality is a long document in Latin, one sheet of which contains the formal evidence of affiliation and the other the list of indulgences and privileges which this affiliation confers. Immediately on receiving this diploma it is well to have it framed in glass and hung up in some prominent place, as it often happens that years afterward a doubt arises whether affiliation was obtained and the diploma cannot be found as proof. A record of all the affiliated sodalities is kept in the office of "The Queen's Work" at St. Louis, but such records are sometimes imperfect and the best proof of affiliation is a diploma. Where there is doubt as to valid affiliation it is best to make application for a new diploma.

There is no charge for the procedure of affiliation but remittance may be sent to cover incidental expenses of postage, secretarial work, etc. The Head Sodality at Rome merely communicates its privileges and indulgences by affiliation. It does not assume control over the affiliated sodality nor send it any direct communication except the diploma. Each sodality remains entirely in the hands of the bishop, who is responsible for its existence, and of the director whom he appoints to take care of it. Each affiliated society is expected to try to carry out the ideals as formulated in the rules. All these rules are not of equal importance. Some of them deal with subjects which concern the very essence of the sodality, others are directive and suggestive. But all should be read and considered by the director, the sub-directress, and the officers.

Several books which have been issued to explain the rules may be had of any Catholic book seller. "Children of Mary, Talks on the Sodality Rules," explains those rules of the sodality which have specially to do with the personal sanctification of members. "Social Organization in Parishes" tells of methods of organization among sodalities in general and of the many good works which have been found practical from time to time. It includes several chapters on nurses' sodalities in particular. Finally, "Sodality Conference," recently issued, contains chapters on the rules not treated in "Children of Mary," explaining especially those rules which have to do with the management and conduct of the sodality. "A Vade Mecum for Nurses and Social Workers" has several chapters on nurses' sodalities.

Before beginning a sodality, the one who is to be the organizer, whether priest or Sister, will do well to read carefully the literature on the subject so as to have definite and practical ideas about what is to be done. Incorrect notions about the sodality have caused many failures. If we do not know precisely whither we are going, it is no wonder if we cannot find the way. This preliminary study will be amply repaid by the good results secured. Where there has hitherto been comparative failure with the sodality for nurses, those in charge may find it useful to consider whether sufficient information is had about methods and ideas. The material available in the books just mentioned is not the result of any one person's experience but comes from observations and from intercourse with many who have had some part in the management of sodalities.

When the time comes for holding the first reception and beginning the meetings, care should be taken to make a right start. The sodalists should realize from the first that they are not joining a mere pious confraternity but are enlisting in a real crusade of activity as well as devotion and prayer, a life-long service of the Mother of God. For this reason it is sometimes well to ask those who are not resolved to be faithful sodalists to withdraw their names before the reception, and when some do this, it should be taken as a good sign. It is not necessary that all Catholic nurses be sodality members. Observe that the requisites for a class A sodality do not demand any large proportion of membership but only require a 90 per cent attendance of those who are members. It is much better to have a very fervent, though smaller, group in the sodality, than to have many members but little fervor—a series of names on a list, and nothing more.

One of the first steps at the meeting is to teach the sodalists how to say the office of the Blessed Virgin, allowing the officers to recite the versicles and the members to make the responses. The office should be said with attention, not in a sing-song voice, but with expression. The first part of the hymns may be said by the officers and the second part by the members. The prefect says, "Let us pray," and all recite the prayers together.

The organization of the sections may be undertaken one at a time as the opportunity offers. Begin with those which seem to appeal most to the nurses and can be most readily and successfully organized, giving preference to the activities that appear most necessary and fruitful under the circumstances. Sections for frequent Communion, for good reading, and for the help of missions, are particularly practical. With patience and perseverance a good sodality may be built up even under the difficult circumstances of hospital life with its many demands on time and energy.

SODALITY HAS FIRST RETREAT

On February 14th the Reverend James J. Lynch, C.S.R., opened the first retreat given to the Sodality of the Blessed Virgin Mary in St. Joseph's Hospital, Lancaster, Pennsylvania. The members of the sodality are the student nurses of the hospital's training school.

It was a source of great pleasure to Sister M. Geraldine, O. S. F., superintendent of the training school, and to all the Sisters of the Third Order of St. Francis, who are in charge of the hospital, to see the nurses enter whole-heartedly into the spirit of the retreat. The non-Catholic nurses relieved the sodalists of their duties in order that they might attend every exercise.

Conferences were held in the chapel from 9 A. M. to 3 P. M. and at 7:30 P. M. on Friday, Saturday, and Sunday. The nurses received holy communion in a body at the 6 o'clock mass Sunday morning. Again by request of the nurses, the Reverend Father Lynch offered mass on Monday for the repose of the soul of Miss Nelda Schutt, a member of the training school who died January 21st, 1924, and all the nurses received the Bread of Life for the same intention.

NURSES' TRAINING SCHOOL NOTES

St. Vincent's Alumnae Hold Meeting. St. Vincent's Hospital Alumnae of Los Angeles, Calif., held their monthly meeting on February 6th, at the nurses' home.

The business meeting which took place in the living room was called to order by the president, Miss Jacobson. The minutes of the last meeting were read and approved. The committee on the card party, given on January 16th, reported the sum of $420 as proceeds from the sale of tickets. The motion was made and seconded, that all available money be placed in a special account for the alumnae, and that all bonds be disposed of, and the amount added to the special fund. The members present discussed the gathering of the fund to be used in endowing a room in the new hospital building.

The matter of nurses receiving social telephone calls while on duty was taken up and a committee appointed to place the matter before Sister Mary Ann for adjustment.

The alumnae held a dance on February 28th, in the Knights of Columbus Hall, the proceeds being devoted to the Endowment Fund of the hospital.

At the conclusion of the business session, the alumnae joined the student nurses in the tea room, where a lunch had been prepared by Sister May. The remainder of the evening was spent in dancing and listening to the radio. At the close of the evening, the members of the alumnae expressed their appreciation to the younger nurses for the delightful evening.

Nurse is Prom Queen. Miss Cecil Runte, of Oshkosh, Wisconsin, president of the junior class at the Marquette University School for Nurses, Milwaukee, was chosen by Harold V. Schoenecker, king of the Marquette University Prom, February 27th, 28th, and 29th, as his partner for the three-day festivities.

MISS CECIL RUNTE.

This is the third time the Marquette Prom Queen has been chosen from the Nurses' School. Last year the honor went to Miss Viola Holtz of Green Bay, Wisconsin. In 1921 Miss Adelaide Mayer of Kenosha, Wisconsin, was first lady of the formal prom.

Nurses Organize Social Club. The nurses of St. Anthony's Hospital Alumnae Association, Terre Haute, Indiana, recently organized a Needle and Card Club which meets bi-monthly in the recreation hall of the hospital. Two of the members, as hostesses, serve light refreshments. Good fellowship prevails and no dues are payable. The regular monthly meeting is devoted to the discussion of matters of a business nature, and hope-chest now under preparation for disposal at Easter time, is expected to increase the club's fund considerably.

Medical Mission Notes

NON-CATHOLIC MEDICAL MISSIONS

Floyd Keeler, Maryknoll Preparatory College, Clarks Summit, Pa.

It is generally conceded that in the way of material equipment modern Protestant missions greatly excel our Catholic ones. They usually have more money at their command and they administer their affairs with a good deal more of what the world calls "business ability." This is one reason. Another, which leads directly to the first, is that the majority of non-Catholic missions are English or American in origin, whereas the greater portion of the missions established by the Catholic church have been staffed and managed by French, German, or Italian missionaries. When an occasional American has gone into the foreign field he has gone under the auspices of a European society and his individuality as an American has been completely submerged. Without detracting in the least from the sterling accomplishments of these continental missioners, it is undoubtedly true that no European peoples except those of the British Isles perhaps, do have exactly the same feeling with regard to material things that Americans do, or see any necessity for what to an American is part and parcel of his make-up.

The English Catholic body has done wonderful work at home, and in proportion to its numbers has not been behind in the foreign field, but it could not be expected to supply either personnel or financial support in large measure. Such great societies as Mill Hill, for example, do not find it possible to draw all their recruits from Great Britain alone, but after making all such allowances, English Catholicism has done wonderfully well. When we in America measure up proportionately, the story of Catholic missions will be a different and more cheering tale.

Modern missions are generally divided into three main departments, evangelistic, educational and medical. In the first of these Catholic missionaries outshine all others, even where their material resources are poor. Protestants seldom show the number of converts that Catholics secure, and in spite of some excellent non-Catholic mission schools, Catholic educational institutions succeed in imparting that firm foundation of morality and religion which is so characteristic of the church's system, thus laying the basis for true Christian life better than do those outside the fold.

Since we are admittedly ahead in these two particulars, why is it that we are so far behind in medical missions? Is it that we have been so centered upon the world to come that we have forgotten that the pagan lives in this one? Have we forgotten that it is difficult for grace to begin its work in a body diseased and full of pain, and that one of the credentials our Lord Himself gave His apostles was that they should "heal the sick?" Whether or not this is the cause, the effect is there, and we must realize that in many places we shall lose precious opportunities for winning souls if we continue to neglect the medical side of mission activity.

The necessity for work along these three-fold lines is apparent to every one who gives the subject any thought. The position of the missionary physician is well stated thus:

"The missionary doctor is the incarnation of one very essential element in Christianity, the ministry of intelligent mercy. A race of people who lack an ideal of mercy as applied to the comfort of the aged, the defective, and the afflicted, can make little progress along any intellectual or spiritual line."

The "Service Calls" of the Student Volunteer Movement for 1923 set forth urgent need for thirty-seven physicians, of whom twenty should be women. They are desired to be placed as follows: four men and four women in China; one man and thirteen women in India; two men and one woman in Africa; two women in Korea; one man in Siam; three men in Persia; and three men for South American hospitals. According to available statistics for China alone, Protestant missions are credited with 320 hospitals and 318 dispensaries, staffed by 270 foreign men physicians, 181 foreign women physicians and 162 nurses, assisted by 212 Chinese physicians and 895 native nurses. In connection with these are twenty-one medical schools and sixty-five schools for nurses having respectively 452 and 715 students. These are, of course, one great hope for the future of their missions. A group of native practitioners imbued with Protestant doctrine, who by precept and example are preaching it among their pagan neighbors, is thus being brought into being.

Catholic medical activity is reported to embrace 100 hospitals and 400 dispensaries, but many of the former are little more than infirmaries attached to the missions, and not a few of the latter are merely the missionary's medicine shelf reserved for the worst cases among his flock. No mention of missionary physicians is made at all, nor is the number of nurses given, but it is safe to say that they are very few. Although the hospital of the Columban Fathers at Han-Yang is being conducted along modern lines, in many cases medical aid is merely dispensed by a nun with training as a nurse, or a mission priest upon whom necessity has laid the burden of this work. The latter undertakes to treat the ills of his flock because charity allows him to do no less but he has to place the burden of recovery upon the mercies of God, rather than to trust in his primitive means of cure.

Protestant mission personnel is of no second-rate order. As a rule physicians must be graduated from class A medical colleges and must have had a year's internship. The nurses are expected to be graduates of a training school qualifying them for the rating of registered nurses. If they have had additional experience either in their profession or along educational lines, so much the better. In the case of both the doctor and the nurse there is no room for the half-educated, unsuccessful, or merely enthusiastic person who has not the sound qualities and the poise of character which make a good missionary.

Confining ourselves to China again—for which country alone I have complete and accurate figures—we find that the previously enumerated non-Catholic medical agencies treated the astonishing number of 1,440,461 persons; 29,675 major operations were performed, and the missions themselves made practically self-supporting (outside of foreign workers' salaries) by Chinese contributions amounting to $862,086. Were statistics at hand similar conditions would be found in practically every mission field. The medical missionary is welcomed where the evangelist is driven out and where the schoolmaster is not particularly wanted. Man may be careless about his soul, or about the development of his mind, but he seldom ignores the ills of his body, and he who comes to him with relief for these will stand a good chance of being heard when he presents religious matters.

As regards salary, allowances, furlough, etc., the status of the medical missionary with most, if not all, Protestant boards, is substantially the same as that of the missionary who goes out in any other capacity. With reference to the spiritual side of his calling, the Methodist Episcopal Board in its Personnel Manual says, "He has little time, as a rule, for sermons or religious addresses, yet because of the exceptional opportunity which he has for breaking down prejudice and of reaching religiously those he is called to serve, he should be a man of definite spiritual and religious experience and purpose." In other words, he is to do just what a consecrated layman ought to do everywhere—apply his Christian experience and life to every day works.

It is significant that non-Catholic mission organizations without exception consider such example worth paying for, and that coupled with the requisite professional skill, such a man is looked upon as one of the greatest "drawing-cards" a mission can have. Instances almost without number could be adduced where the evangelist's work has been made possible only because the medical missionary preceded him. Sometimes the most inaccessible strongholds of paganism are opened to the heralds of the cross by this means. Lhasa, the "forbidden city," was entered first in modern times by a Protestant medical missionary whose work so pleased the Dalai Lama that he was personally invited to come to see what could be done for the physical well being of his people. This same devoted missionary doctor afterwards sealed his faith with his blood when set upon by Chinese bandits as he was returning from Thibet.

A GROUP OF PATIENTS IN FRONT OF ST. CATHERINE'S HOSPITAL FOR WOMEN AND CHILDREN AT RAWAL PINDI. ARROW POINTS TO DOCTOR DENGEL, WOMAN PHYSICIAN AND SURGEON.

It does not fall within the scope of this article to outline what the missions of the Catholic church need to do with reference to this most important branch of missionary service to mankind, nor to point out what to adopt in these non-Catholic methods in order that we may do our duty by our own. But in the face of the fact that we have thus far done practically nothing, that our best known and most zealously interested Catholic medical missionary, Margaret Lamont, would long since have starved to death for all the aid the agencies of the church have given her, it does behoove those of us who have the matter at heart to outline some plan, to put it into operation, and to learn by experiment what changes may later be necessary. Anything is better than nothing, and we cannot longer escape the charge of standing by and watching the world's misery, looking on the place where it lies physically wounded, and passing by on the other side. The very least we can ask is that the cause for such a charge be eliminated, and that much we do demand of the American Catholic church and those who are responsible for its missionary policy. We cannot believe that they will fail to respond.

HOSPITAL RECEIVES HUGE GIFT FOR NURSES' HOME

There has been general and genuine rejoicing at the Hospital of St. Raphael in New Haven, Connecticut, since Mr. Truman S. Lewis, retired manufacturer, announced his intention of presenting the hospital with a nurses' home as a memorial to his recently deceased wife, Selina Marie Lewis.

When a patient at Saint Raphael's a few years ago, Mrs. Lewis manifested a keen interest in all that pertained to its progress, and thereafter both Mr. and Mrs. Lewis kept the institution and its needs in kindly and generous remembrance.

Since the death of Mrs. Lewis on January 13th of this year, it has been the desire of Mr. Lewis to erect a monument in her honor. Recalling her oft repeated wish to do something substantial for Saint Raphael's, and realizing that a separate building for the student body was the most urgent need, Mr. Lewis at once set about arranging to present to the hospital the sum of one hundred thousand dollars for that purpose. The gift was formally handed over to St. Raphael's board of trustees in February.

At the conclusion of divine services in the hospital chapel on the following Sunday, the congregation joined in singing "Te Deum" in thanksgiving to Almighty God for inspiring a friend and well-wisher to so munificently come to the assistance of the hospital.

There will be no delay on the part of hospital authorities in selecting plans and specifications for the long desired and much needed home, to stand as an enduring and fitting tribute to the memory of a gentle, love-worthy woman.

HOSPITAL DAY PLANS

Baby shows and emphasis on the opportunities of nursing continue to be the outstanding items in the development of programs for National Hospital Day, according to announcements from various hospitals throughout the United States and Canada which are being received by the National Hospital Day Committee, Matthew O. Foley, Executive Secretary, 537 South Dearborn Street, Chicago.